INTERAGENCY COMMITTEE ON SMOKING AND HEALTH
NATIONAL ADVISORY COMMITTEE

PREVENTING THE SALE OF TOBACCO TO MINORS

MAY 31, 1990

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NATIONAL ADVISORY COMMITTEE

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INTERAGENCY COMMITTEE ON SMOKING AND HEALTH
NATIONAL ADVISORY COMMITTEE

MAY 31, 1990

CHAIRPERSON

Antonia Coello Novello, M.D., M.P.H.

Antonia C. Novello, M.D., M.P.H. is the Surgeon General of the Public Health Service. She serves as Chairperson of the Interagency Committee on Smoking and Health. Born in Fajardo, Puerto Rico, Dr. Novello received an M.D. from the University of Puerto Rico, and an M.P.H. from Johns Hopkins University. Formerly the deputy director of the National Institute of Child Health and Human Development, Dr. Novello was Institute

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NATIONAL ADVISORY COMMITTEE EXECUTIVE SECRETARY

John L. Bagrosky

Mr. Bagrosky, who serves as the Executive Secretary of this Committee, is also Associate Director of the Office on Smoking and Health of the Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control. Mr. Bagrosky has been with the Office since its inception in 1978, and is Managing Editor for the Department of Health and Human Services' Report to Congress, *Smoking and Health: A National Status Report*.

PUBLIC MEMBERS

Lonnie R. Bristow, M.D.

Dr. Bristow is an internist from San Pablo, California. Among the positions he has held are, R President of the California Society of Internal Medicine and the American Society of Internal Medicine. He was also honored in 1977 by his election to membership in the

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Edward L. Calhoon, M.D.

Dr. Calhoon is a surgeon from Beaver, Oklahoma. He is an Oklahoma delegate to the American Medical Association.

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John H. Holbrook, M.D.

Dr. Holbrook is Professor of Medicine, University of Utah School of Medicine. He has written extensively on the subject of smoking and has served as Consulting Editor for 12 Surgeon General's reports to Congress on the health consequences of smoking. Dr. Holbrook began his medical career as a medical officer for the National Clearinghouse for Smoking and Health.

Robert V.P. Hutter, M.D.

Dr. Hutter is Clinical Professor, Department of Pathology, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, and Chairman of the Department of Pathology for Saint Barnabas Medical Center. He is an active member of the R and is currently serving on a number of their committees, including the Committee on Tobacco and Cancer. Dr. Hutter is a past president of the and currently chairs the R

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John Seffrin, Ph.D.

Dr. Seffrin is the Professor and Chairman of the Department of Applied Health Science, Indiana University. He is also the Director of the Center for Health and Safety Studies, and a member of the Graduate Faculty, Indiana University Graduate School. He received a B.S. from Ball State University, an M.S. from the University of Illinois and a Ph.D. in Health Education from Purdue University. Dr. Seffrin is the

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Jeffrey Axelrad, Esq. (Alternate for Mr. Bransdorfer)

Mr. Axelrad serves as Director, Torts Branch, Civil Division, United States Department of Justice. Also, he serves as Assistant to the Chairman of the Domestic Policy Council's Tort Law Reform Working Group.

Claudia R. Baquet, M.D., M.P.H.

Dr. Baquet is the Associate Director of the Division of Cancer Control Science Program, National Cancer Institute, National Institutes of Health.

Carlene Bawden, Ph.D.

Dr. Bawden is the Associate Administrator of the General Services Administration.

Stephen Bransdorfer, Esq.

Mr. Bransdorfer is the Deputy Assistant Attorney General, Civil Division, of the U.S. Department of Justice.

Eileen D. Claussen

Ms. Claussen is Director of the Office of Atmospheric and Indoor Programs under the Assistant Administrator of Air and Radiation in the Environmental Protection Agency. She is responsible for the development and implementation of the Agency's policies on indoor air pollution (which includes environmental tobacco smoke), as well as programs on acid rain and stratospheric ozone.

Dorynne J. Czechowicz, M.D.

Previously Board certified in Pathology, Dr. Czechowicz is now a child psychiatrist who has been with the National Institute on Drug Abuse since 1977. Prior to this, she was with the Bureau of Drugs of the Food and Drug Administration. Dr. Czechowicz is currently Associate Director for Medical and Professional Affairs in the Office of Policy and External Affairs, Office of the Director, National Institute on Drug Abuse.

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Ronald M. Davis, M.D.

Dr. Davis is the Director of the Office on Smoking and Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control. Dr. Davis was elected as the first resident member of the American Medical Association's Board of Trustees. He is an alumnus of the Centers for Disease Control's Epidemic Intelligence Service, and is one of twelve members of the World Health Organization's Technical Advisory Group on Tobacco or Health.

Christopher DeGraw, M.D., M.P.H. (Alternate for Dr. McGinnis)

Dr. DeGraw, a pediatrician, serves as Coordinator of Children and Schools Programs for the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Public Health Service.

Francis Frodyma

Mr. Frodyma is Deputy Director of Policy for the Occupational Safety and Health Administration, U.S. Department of Labor. The Policy Office serves as staff support to the Assistant Secretary and prepares policy alternatives to the Assistant Secretary for consideration.

Robert G. Harmon, M.D., M.P.H.

Dr. Harmon is Administrator of the Health Resources and Services Administration of the U.S. Public Health Service. Formerly Director of the Missouri Department of Health and professor of family and community medicine at the University of Missouri, he co-authored *The Future of Public Health.*

John Mazzuchi, Ph.D.

Dr. Mazzuchi is the Principal Director for the Office of the Assistant Secretary of Defense for Health Affairs, Professional Affairs and Quality Assurance. For the past 17 years, he has been responsible for providing guidance on health policy in the areas of health promotion, disease prevention, and medical quality assurance. Before Dr. Mazzuchi joined Health Affairs in 1973, he was a research psychologist with the Department of the Navy.

J. Michael McGinnis, M.D. (Alternate: Dr. DeGraw)

Dr. McGinnis is the Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion). He chaired the 1978-1979 Secretary's Task Force on Smoking and Health and since 1982 has worked as a volunteer with the Latin American Program on Smoking and Health.

Phillip A. Miller, Ph.D. (Alternate: Dr. Jane Robens).

Dr. Miller is the National Program Leader for Fiber, Oil, and Tobacco for the U.S. Department of Agriculture, Agricultural Research Service. In this position, he has responsibility for leading and coordinating the USDA programs for cotton, kenaf, soybean, peanut, sunflower, and tobacco production research.

Gregory J. Morosco, Ph.D., M.P.H.

Dr. Morosco is the Acting Director, Office of Prevention, Education, and Control, National Heart, Lung and Blood Institute (NHLBI). He is also the Coordinator, NHLBI Smoking Education Program, and Chief, Health Education Branch. Dr. Morosco has been involved in basic and applied tobacco-related research as well as the development and implementation of smoking prevention and cessation programs targeting health care providers and the public.

Linda Mount, Ph.D.

Dr. Mount is the Program Manager of the Consumer Affairs Program for the U.S. Department of Education. Previously, she was the Women's Concerns Advisor for the Department. Dr. Mount's particular interest is in counseling programs at the neighborhood and community level.

Charles Q. North, M.D., M.S.

Dr. North is a Commissioned Officer of the U.S. Public Health Service and Senior Clinician for Family Practice in the Indian Health Service. He is a faculty member of the University of New Mexico. In 1983, Dr. North helped to establish the first 100% smoke-free hospital policy in the country.

Jane Robens, D.V.M. (Alternate for Dr. Miller)

Dr. Robens, National Program Leader for Food Safety and Health, is a veterinarian (Cornell 1955) with particular experience in toxicology. She has experience with private industry (pharmaceutical), as well as with regulatory agencies, including the Food and Drug Administration.

William A. Robinson, M.D., M.P.H.

Dr. Robinson is the Director for the Office of Minority Health in the Office of the Assistant Secretary for Health. Previously, Dr. Robinson served as Chief Medical Officer of the Health Resources and Services Administration, and a Deputy Director in the Bureau of Health Professions. He has served as a member of the Secretary's Task Force on Black and Minority Health and served as a health consultant to the Committee on Interior and Insular Affairs for the House of Representatives.

Patrick J. Scheer, M.B.A.

Mr. Scheer is the Coordinator for the Department of Veterans Affairs (VA) Preventive Medicine Program. He was previously the Executive Officer for the VA's Physical Fitness Program. Prior to that time, he was the Administrative Coordinator for the VA's Geriatric Research, Education and Clinical Centers.

Donald R. Shopland (Alternate for Dr. Baquet)

Mr. Shopland is currently with the Smoking, Tobacco, and Cancer Programs, National Cancer Institute (NCI). Mr. Shopland has contributed to 22 reports on smoking and health prepared by the Department, including the original report issued in 1964. Between 1978 and 1986 he was managing and executive editor of the Surgeon General's report on smoking and health; and prior to joining NCI in 1987, Mr. Shopland was with the Office on Smoking and Health serving for two years as Acting Director.

Henry J. Singer (Alternate for Dr. Bawden)

Mr. Singer is the Director, Safety and Environmental Management Division of the General Services Administration (GSA). His responsibilities include GSA's asbestos, radon, and indoor air quality programs.

Dennis Tolsma, M.P.H.

Mr. Tolsma is the Assistant Director for Public Health Practice of the Centers for Disease Control in Atlanta, Georgia. Previously, he served as the Director of the Center for Health Promotion and Education. He has been president of the International Union for Health Education since 1988. Mr. Tolsma is one of the principal architects of the prevention policy documents, *Healthy People* and *Disease Prevention, Health Promotion: Objectives for the Nation.*

Judith Wilkenfield, Esq.

Ms. Wilkenfeld is Assistant Director of the Division of Advertising Practices at the Federal Trade Commission. She is responsible for the initiation and supervision of all cigarette and tobacco-related advertising matters. She currently handles litigation and recommendations to Congress.

Sumner J. Yaffe, M.D.

Dr. Yaffe is the Director of the Center for Research for Mothers and Children, National Institute of Child Health and Human Development. He is an active member on numerous national committees concerned with pediatric and human development and has conducted extensive research on the effects of drug exposure during pregnancy.

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NATIONAL ADVISORY COMMITTEE

PREVENTING THE SALE OF TOBACCO TO MINORS

MAY 31, 1990

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INTERAGENCY COMMITTEE ON SMOKING AND HEALTH
NATIONAL ADVISORY COMMITTEE

PREVENTING THE SALE OF TOBACCO TO MINORS

MAY 31, 1990

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(Special Presenter)
Sir George A. O. Alleyne, M.D.

A native of Barbados, Dr. Alleyne was appointed Assistant Director of the Pan American Health Organization in 1990. He became Chief of the Research Unit of the Pan American Health Unit in 1981, and in 1983 was appointed Director of the Area of Health Programs Development in the same organization. In 1990, Sir George Alleyne was made Knight Bachelor by her Majesty Queen Elizabeth in her New Year's Honours.

Jean L. Forster, Ph.D., M.P.H.

Dr. Forster is an Assistant Professor in the Division of Epidemiology at the University of Minnesota. She has served as principal investigator for various tobacco-related studies. These studies examined the feasibility of community intervention to limit access of tobacco to adolescents and children; the effects of restrictions on vending machines; the effects of educating merchants on limiting teenage access to tobacco products, and the evaluation of worksite no-smoking policies in Minnesota schools. Dr. Forster received a doctorate in genetics from the University of Minnesota and an M.P.H. from the University of North Carolina.

Edward Greer, J.D., M.P.H.

Mr. Greer has been a sole practitioner of public-interest-oriented civil litigation since 1979. He currently serves as a Senior Fellow at the American Civil Liberties Union. Mr. Greer has written several books, including his most recent, *Toxic Tort Litigation,* which was published in 1989. He also has written numerous articles, which have been published in *The Nation, Politics and Society,* and *Environmental Affairs.* Mr. Greer received advanced degrees from Yale Law School and the Harvard School of Public Health.

Bruce Talbot, M.P.A.

A 12-year veteran of the Woodridge, Illinois police department, Officer Talbot teaches a drug abuse resistance education program to 1,500 students. He has special training and experience in drug recognition and accident investigation. Officer Talbot received a degree in law enforcement from Southern Illinois University and a Master's of Public Administration from Roosevelt University in Chicago, Illinois. Officer Talbot is the principal author of a successful city ordinance to license the sale of tobacco products, the first such law in Illinois. He recently testified before the Senate Labor and Human Resources Committee regarding the proposed Kennedy/Hatch Tobacco Control Act.

Joe B. Tye

Mr. Tye is chief operating officer of Baystate Medical Center, as well as founder and president of Stop Teenage Addiction to Tobacco (STAT). STAT is a nonprofit educational organization devoted to eliminating the tobacco industry's efforts to encourage nicotine addiction among young people, and to eliminating the sale of tobacco products to minors. Through the efforts of Mr. Tye, STAT has recruited over 5,000 members and over 10,000 readers for the STAT publication, *Tobacco Youth Reporter*. Mr. Tye has conducted a variety of projects to raise public awareness of unethical marketing campaigns used by tobacco companies, and to eliminate the sale of tobacco to minors.

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STATEMENT FROM THE
PAN AMERICAN HEALTH ORGANIZATION

WORLD NO-TOBACCO DAY
MAY 31, 1990

Good morning. I would like to thank the organizers of this meeting and particularly the Surgeon General, Dr. Antonia Novello, for the opportunity to participate in this event.

It is a happy coincidence that this new initiative to restrict the access of minors to the purchase of cigarettes is being launched today, because today, May 31, is World No-Tobacco Day and the theme for this day, which is being observed world-wide, is "Childhood and Youth Without Tobacco." Let me congratulate you, Dr. Novello, in this initiative.

The World Health Organization and the Pan American Health Organization are focusing on smoking and youth as part of their effort to encourage governments, communities, groups and individuals to ban the use of tobacco. We are particularly concerned about the youth, as children are often innocent victims of tobacco through passive smoking.

Unborn children may pay a high price for their mothers' smoking habits. Smoking during pregnancy has been associated with premature births, spontaneous abortion, fetal and perinatal deaths; it also causes the Fetal Tobacco Syndrome, which is associated with low-birth weight, poor growth, and possible congenital defects. Young people are increasingly the object of deliberate manipulation by tobacco companies whose survival depends on this future market as they try to compensate for the large number of adult smokers who die or stop smoking. Our youth are being tempted by slick publicity campaigns which falsely associate youth, beauty, success, wealth, sports, and sex with smoking. It is alarming to note that 3,000 adolescents take up smoking each day in the United States, and the pattern is being repeated in the rest of the continent. We agonize because a significant proportion of those who start smoking in their youth acquire the habit for life, and even worse is the fact that in many cases, tobacco represents a "transition drug" which leads to other, more serious addictions.

Tobacco use is starting at earlier and earlier ages, particularly among young women in industrialized countries, and among adolescents in developing countries. Despite some laws restricting advertising and access to tobacco, too many young people still consider smoking socially acceptable, partly due to clever advertising linking smoking with fun. Advertising directly influences the decision to start smoking, and in countries where tobacco advertising has been restricted, such as Norway, there has been a reduction in smoking prevalence among young people.

This deliberate attempt to induce the youth to smoke more is carried out, not only through well-designed advertising, but also through the sale of cigarettes in small packages of six or less, or even single cigarettes, which are more affordable to school children and other youth.

The initiative which the United States Surgeon General is launching today on preventing the sale of tobacco to minors is an opportune and potentially powerful mechanism for reducing consumption of tobacco among youth.

There is very gross evidence that tobacco use and production continue to increase in Latin America, but our data are incomplete. To gain a clearer picture and collect up-to-date information on the use of tobacco in this hemisphere, PAHO and the U.S. Office on Smoking and Health have agreed to work together, and with the assistance of experts in tobacco control, economics, health, marketing, law, and other fields, we are preparing a joint report on "Smoking in the Americas." This report will constitute a major step towards focusing international cooperation on addressing the epidemic of tobacco use and its consequences. I wish to take this opportunity to thank Dr. Novello for her support of this project.

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We know that prevention and control of tobacco consumption are technically and economically feasible, as well as socially necessary and politically viable. But we do not have the resources of the tobacco companies and cannot afford to match their expensive campaigns with counter-advertisements in order to convince people to stop smoking and help prevent millions of unnecessary deaths. We must rely on the governments, the non-governmental organizations, the schools, and especially young people themselves to join our efforts and work towards the goals of a tobacco-free society. I hope that this meeting will contribute in a significant way to mobilizing the human financial, political, institutional and popular resources necessary for us to reach this goal.

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Remarks of Joe B. Tye
President
Stop Teenage Addiction To Tobacco (STAT)
Springfield, Massachusetts

PREVENTING THE SALE OF TOBACCO TO MINORS: A COMPREHENSIVE APPROACH TO REDUCING JUVENILE NICOTINE ADDICTION

"It's not the last pack of cigarettes that kills you. It's the first."

High school football coach Hugh McCabe,
who died of cigarette-caused lung cancer

AN EPIDEMIC OF TEENAGE TOBACCO ADDICTION

In the United States today, more than three million children under the age of 18 years regularly smoke cigarettes or use smokeless tobacco. They are sold approximately $1.25 billion in tobacco annually. More than two million others are actively experimenting with tobacco use, and at high risk for becoming regular users. [1]

More than half of these children begin using tobacco before the age of 14 years, and 90% begin by the age of 19 years. For many of these youngsters, childhood use of tobacco will be the first step down the road of addiction, disease, and death. For some, tobacco will be their first experience with using, and becoming dependent upon, a chemical substance to modulate their moods and feelings, and will facilitate their progression to other, illicit drug use.

Tobacco use by young people is a problem easily understandable in terms of economic demand and supply. A major factor in creating demand for tobacco within young age groups is tobacco industry advertising and promotion. Inadequate and unenforced laws assure that this demand is met with a readily available supply. Furthermore, in accordance with the economics priniciple of Say's Law, the ready supply of cigarettes and other tobacco products can, in and of itself, augment demand (the fundamental argument of the "supply siders").

In the six years following the introduction of Virginia Slims and other "feminine" cigarettes in 1968, the number of teenage girls who regularly smoke more than doubled so that by the mid-1970s, teenage smoking reached an apparent peak. During the late 1970's, the rate of smoking among teenage boys decreased while female smoking remained intractably high. In retrospect, the decline in male smoking was probably less a function of successful health education than it was of aggressive marketing by smokeless tobacco companies. During the early and mid-1980s, teenage tobacco use rates appear to have stabilized, albeit at an unacceptably high rate. [2]

Unfortunately, although smoking in the adult population is declining, there is growing evidence that smoking by teenagers has been increasing over the past few years. [3,4] This is probably a response to massive increases in tobacco company advertising and promotional campaigns that directly target young people.

Tobacco is, in the words of a former director of the National Institute on Drug Abuse, "a powerfully addictive drug." [5] The Surgeon General's 1989 report on nicotine addiction concluded that nicotine is as addictive as heroin. According to Dr. Neal Benowitz, a leading authority on nicotine addiction, a child who smokes just one pack of cigarettes will develop a substantial tolerance to the drug effects of nicotine, which is the first step in the addiction process. [6]

The earlier a person begins smoking, the more unlikely it is that they will be able to quit later as adults, and the more likely it is that they will suffer and die from a disease caused by smoking, [7]

For many young people, tobacco serves as a gateway drug, introducing them to the use of chemical substances to modulate moods, and conditioning them to physical dependence on drugs. Former NIDA Director R. DuPont concluded that "prevention of cigarette smoking is a high priority in the prevention of dependence on all drugs." [8]

EASY ACCESS TO A DRUG INCREASES CONSUMPTION

Although 43 States and the District of Columbia prohibit the sale of tobacco to minors—most often defined as anyone under the age of 18 years—youngsters who want to obtain cigarettes find it easy to do so. An estimated one billion packs of cigarettes are sold to minors under the age of 18 years every year, usually in violation of the law. [1] The National Adolescent Student Health Survey of 12,000 students found that 86% of respondents believed it would be easy for them to obtain cigarettes. [9]

There are many reasons to prevent minors from obtaining tobacco products. First, easy availability conveys a message that the substance is not really very harmful. Second, illegal tobacco sales to minors foster disrespect for the law, and may help young people build the nerve to partake of illegal sales of alcohol or illicit drugs. Third and most obvious, the harder it is for young people to obtain tobacco, the fewer will use the substance.

Easy access to any drug increases usage of that drug, including nicotine. In his book on the vast social problems created by heroin addiction, Richard Kaplan describes the analogy with tobacco: "As many cigarette smokers have found out, the ready availability of that drug has two major effects. First, it increases the amount they use at those times when they want to smoke; and second, the fact that they can always start again easily, even after they have stopped use, increases their difficulty in giving up the drug completely." [10]

As Kaplan notes in his book, it has been shown by historical example that reducing access to a drug will reduce consumption of that drug:

> Opium consumption dropped sharply in England after 1868 when, though use of the drug remained legal, it could only be acquired through pharmacies.
>
> Fourteen percent of American soldiers in Viet Nam used heroin, which was cheaply and easily available. Upon return to the U.S., where heroin is relatively expensive and difficult to obtain, 70 percent of heroin users quit.
>
> In China, a widespread opium addiction began to resolve only after the government, in the early part of this century, began to impose draconian punishments on its sale and use.
>
> The prohibition of alcohol in this country, though a failure as social policy, did, in fact, reduce consumption.

Though it seems obvious that increasing availability increases drug use among young people, and conversely, reducing availability should decrease use, there have been few empirical studies. The incredible increase of cocaine availability over the past ten years is no doubt substantially responsible for the increase in cocaine consumption among young people over the same period.

In the case of alcohol, one effect of raising the legal drinking age to 21 years has been a reduction of alcohol purchases and consumption by teenagers. During the first year that the drinking age in New York was raised from 19 to 21 years, alcohol purchases by 16-20-year-olds decreased by half, and alcohol consumption among this age group dropped by 21%. [11] Between 1982 and 1987, there was a 34% reduction

in the proportion of intoxicated teenagers involved in fatal automobile accidents as a result of raised drinking ages in many States and the changed social acceptability of drinking and driving. [12]

MINORS' ACCESS TO TOBACCO

Notwithstanding that easy access increases consumption, including among young people, most States have taken no effective action to restrict minors' access to tobacco.

Although 44 States have some legislation preventing minors' access to tobacco products, only three (Indiana, Utah, and Idaho) are considered to meet the standards for even "basic" coverage based upon criteria established by the U.S. Office on Smoking and Health, meaning that in addition to establishing a minimum age for sale, there are penalties for merchants selling tobacco to minors and some restrictions on the placement of cigarette vending machines. Six States have no minimum age law whatsoever (Montana, Wyoming, New Mexico, Missouri, Louisiana, and Kentucky). No State law is considered to be "comprehensive," which, in addition to the basic category's requirements would include a requirement for warning signs at the point of purchase, provision to revoke merchant licenses for violation, and a ban on the distribution of free tobacco products. [13]

In his 1989 report, the Surgeon General stated:

> "In marked contrast to the trends in virtually all other areas of smoking control policy, the number of legal restrictions on children's access to tobacco products has decreased over the past quarter century. Studies indicate that compliance with mimimum-age-of-purchase laws is the exception rather than the rule." [14]

TOBACCO SALES TO MINORS FROM RETAIL STORES

Surveys of young people show that they believe it is easy for them to obtain cigarettes and other tobacco products, notwithstanding that in most State such transactions are illegal. The National Adolescent Student Health Survey found that 86% of students believe it would be easy for them to obtain cigarettes. [5]

In studies across the country, it has been shown that on average, 75% of retail stores sell tobacco to minors as young as 12 years old. In one Massachusetts community, an 11-year-old girl was successful in purchasing cigarettes at 75 out of 100 attempts. [15] In the largest trial of this type, 18 minors aged 14 to 16 years visited 412 stores and 30 vending machines with the intent of purchasing cigarettes. They were successful at 74% of the stores and 100% of the vending machines. [16] In Erie Country, New York, minors purchased cigarettes in 77% of stores that had received a special mailing about the law prohibiting tobacco sales to minors, and in 88% of stores that did not receive the mailing. [17]

Trials in at least 18 different communities have yielded similar results: on average, three of four retail stores will sell tobacco to minors, in violation of the laws of their State. [18]

Researchers asked tenth graders in two Minnesota communities, "Have you ever purchased cigarettes from any of these places," with the following results:

Location	Percent Answering "YES"
Drug Stores	42
Grocery Stores	53
Convenience Stores	68
Vending Machines	71
Gas Stations	80

Most teens thought it would be "very easy" (55%) or "fairly easy" (31%) to obtain cigarettes. Among smoking teenagers, 90% thought it was "very easy" to obtain cigarettes. [19]

CIGARETTE VENDING MACHINE SALES TO MINORS

As mentioned above, when minors aged 14 to 16 years attempted to purchase cigarettes from 30 vending machines in Santa Clara County, California, they were successful in all 30. Even after a massive community education program had reduced illegal over-the-counter cigarette sales to minors by 50%, vending machine sales remained at 100% on post-test.

In a major study covering the three-State area surrounding Washington, D.C., Davis and colleagues escorted underage minors to 120 cigarette vending machines (twice each, for a total of 240 attempts). The children were successful in 100% of attempts to buy cigarettes. [20] Davis concluded, "This shows conclusively that teenagers have easy access to cigarette vending machines in three different jurisdictions in the Washington, D.C. area. There is every reason to believe this reflects the situation across the country." [21] Identical results were obtained when underaged minors were escorted to cigarette vending machines in New York City, Colorado and New Brunswick, New Jersey.

A study by the National Automatic Merchandising Association (NAMA), the trade association for the cigarette vending machine business, confirms the impression that vending machines are the source of cigarette supply for many very young teenagers when they first begin to experiment with smoking. The study found that, while only 16% of teens regularly obtained their cigarettes from vending machines (which still represents more than half a million teenagers), vending machines are a key source of supply for young teens. Among the study's conclusions were:

> Thirteen-year-olds are eleven times as likely as seventeen-year-olds to buy cigarettes from vending machines (22% vs. 2%).
>
> Most teens (56%) say they use vending machines "because no one will stop me from buying cigarettes this way."
>
> Whereas, virtually all teenage smokers (96%) had been stopped from buying cigarettes over-the-counter, only about one-in-ten (11%) had ever been stopped from buying cigarettes from a vending machine.

A growing trend is to sell cigarettes and candy from the same vending machines, which is likely to further encourage and facilitate cigarette sales to minors.

FREE CIGARETTE SAMPLES

Tobacco companies spent $265,000,000 giving away free cigarette samples through direct distribution or coupons during 1988, the most recent year for which data are available. [22] One of the key functions of tobacco company give-aways is to provide young people with their first experimental packs of cigarettes of smokeless tobacco products at no cost and little risk of being caught. That young people are the target for many free cigarette distribution campaigns was made clear by a recent Camel advertisement that included a coupon with the encouragement to get a friend or a "kind-looking stranger" to redeem the pack for you if you are uncomfortable, an obvious come-on to underage youth.

Sean Marsee, the Oklahoma youth who died at the age of 18 years of mouth cancer caused by using smokeless tobacco, got started when a tobacco company representative gave him a free pack of snuff at a rodeo. Indeed, the giving away of free samples to young nonusers has been a foundation of the growth strategy of the U.S. Tobacco Company (makers of Skoal, Copenhagen, Happy Days, and other smokeless tobacco products). The company has run advertisements in youth-oriented magazines offering free samples,

complete with instructions for use, and promiscuously gives free samples to young people at music, sporting, and other events.

Davis and colleagues asked a large number of young people if they had personally been given free tobacco samples; 14% of the total and 20% of the high school students responded in the affirmative. Approximately half reported having seen other teenagers given free cigarette samples. [23] DiFranza organized a group of young people to send coupons in response to tobacco company solicitations for free tobacco samples being sent through the mail. Fifteen of twenty were mailed free tobacco samples at home, in violation of Massachusetts State law. [24]

STUDENT SMOKING AREAS IN SCHOOLS

Unfortunately, many schools maintain student smoking areas on campus, despite the fact that in most States, it is illegal for students to purchase and, in some States, to possess tobacco products. This is a vital access-related issue in that officially sanctioned student smoking areas in the schools sends a message to teens that it is acceptable for young people to obtain and use tobacco products.

In one study of two matched schools, the school with a student smoking area showed a significantly higher rate of student smoking than the one without. [25] A study by the California Department of Health Services found that between 1979 and 1983, the proportion of 18-19-year-olds who regularly smoked increased by 18%, while over the same time period the proportion of adult smokers declined. [26] High school smoking areas were first permitted by legislation enacted in 1977 (repealed in 1987).

CIGARETTE PRICES AS AN ACCESS ISSUE

Physical availability of tobacco products is a key access issue for youth smoking, but price is a complementary factor. Cigarettes that are very expensive, even if readily available over-the-counter and through vending machines, will not be truly accessible to many minors. The U.S. Government Accounting Office, building on previous work by Lewit, Warner, and others, recently estimated that a 21-cent increase in the price of a pack of cigarettes would reduce the number of teenage smokers by more than 500,000. [27]

This conclusion seems to be borne out by the experience in jurisdictions where tax increases have been imposed. In Canada, impressive increases in the tobacco taxation rate have resulted in significant reductions in per capita smoking rates. [28] In California, since imposition of the incremental 25 cents per pack tax mandated after voter passage of Proposition 99, there has been a major decline in total cigarette sales in that State (David Altman, Ph.D., personal correspondence). Because adult demand for tobacco is more inelastic than youth demand, it is likely that smoking among young people has decreased at a greater rate than among adults.

ACTION AT THE COMMUNITY LEVEL

Over the past several years, there has been a flurry of activity to prevent the sale of tobacco to minors. Much of this action has been at the community level. For example, in Santa Clara County, California, a major community-wide education campaign resulted in a 50% reduction in the number of stores selling tobacco to minors (from 74% to 38%), though there was no impact on the rate of sale by vending machines, which remained at 100%. [16] A *Tobacco Free Youth Project Users Guide* was developed in conjunction with this project, and has been used to inaugurate similar projects in other communities. [29]

Unfortunately, even a successful community education program is unlikely to have a significant effect on reducing teenage smoking if such a large number of stores continue selling tobacco to minors, since young people will gravitate toward the stores and vending machines that continue to sell to them.

In Woodridge, Illinois, police officer Bruce Talbot successfully pushed for enactment of a local ordinance requiring tobacco merchants to obtain a license, and providing for fines and licensure revocation for

violation of the law prohibiting sale of tobacco to minors under the age of 18 years. Compliance is monitored by means of "sting" operations in which a minor is escorted to stores. If cigarettes are sold to the minor, the store owner receives a fine. Since enactment and enforcement of the law, the number of stores in Woodridge selling tobacco to minors has declined from 92% to zero. Many other Illinois communities have passed or are considering this or similar ordinances. A similar ordinance was passed in unincorporated King County, Washington.

In Minnesota, the town of White Bear Lake outlawed cigarette vending machines in 1989. Since that time, eight other communities have followed suit, eleven have imposed more limited restrictions, and ten others are considering restrictions. A tobacco company effort to enact State legislation that would preempt these local ordinances failed (personal correspondence, Jean Forster, Ph.D.). The State of Utah, based upon evidence that lockout devices that have long been required on cigarette vending machines in that State to prevent use by minors had been ineffective, outlawed cigarette vending machines from all areas accessible to minors. The law was upheld by the Supreme Judicial Court of Utah against a challenge from the vending machine industry.

A number of jurisdictions have outlawed the distribution of free tobacco samples. They are totally prohibited in Minnesota and Utah; it is illegal to distribute smokeless tobacco samples in Nebraska. Eight communities in Massachusetts prohibit the giving away of free tobacco samples.

Another step that is being taken by an increasing number of jurisdictions is to post signs that warn against tobacco sales to minors. This may be not only effective at warning would-be underage tobacco purchasers, but also at reminding store personnel of the law.

A growing number of activists, impatient with the sometimes slow progress of enacting controls over the sale of tobacco to minors—often in the face of determined tobacco industry resistance—have taken to direct action against cigarette vending machines. For example, one antismoking organization published instructions for disabling cigarette vending machines, including the use of bent paperclips and coins dipped in Superglue. Another produces "out of order" stickers that can be placed over the coin slot of cigarette vending machines.

STAT (Stop Teenage Addiction to Tobacco) is a nonprofit educational organization that was founded in 1985 to eliminate adolescent tobacco addiction by raising public awareness of how tobacco companies use sophisticated marketing campaigns to attract young people, and how readily available access increases tobacco consumption among young people. STAT has prepared model legislation that has served as the basis for legislative efforts in a number of communities around the country.

STAT is organizing a national network of Community Organizers to implement strategies that will reduce the sale of tobacco to minors. In August, 1990, more than 300 Community Organizers will gather in Boston for the 1990 STAT Conference to learn more about ending the sale of tobacco to minors in their communities.

A PUBLIC POLICY AGENDA

Eliminating the sale of tobacco to minors is an essential step that must be taken if we are to achieve the national public health goal of a smoke-free society. Based upon research and review of what has been effective at the State and community levels, the following steps are probably necessary:

1. All free distribution, or "sampling" in tobacco industry parlance, must be outlawed. The giving away of free cigarettes and smokeless tobacco products is reminiscent of the drug pusher who gives the first one free in order to get his customer hooked.

2. Legislation at either the State or local level should establish that any merchant must obtain a license prior to selling tobacco products. There must be a provision that repeated violation of the law prohibiting tobacco sales to minors will result in meaningful monetary

fines and/or extended revocation of that license. There should be provision that enforcement will be ensured by means of sting operations conducted by either the police or health department of the jurisdiction (the Tennessee State law explicitly provides that it is not entrapment for a youth under official supervision to attempt to purchase cigarettes to monitor compliance with the law.)

3. Cigarette vending machines must be outlawed. The nation's 374,000 cigarette vending machines are an open invitation to addiction for the nation's young people. A vast majority are located in areas where they cannot be effectively supervised. With the proliferation of 24-hour convenience stores over the past several decades, cigarette vending machines can no longer be justified in light of their potential to begin young people on the course of tobacco addiction.

4. Signs should be required providing notice of the minimum age of purchase law, and the store's intent to abide by the law.

5. Although this will require political willpower, the legal age for the sale of tobacco should be raised to 21 years, consistent with the age for legal sale of alcohol. This will send an important message that tobacco is just as hazardous as alcohol. It will also make it simpler for merchants to monitor identification for sale of products that are legal for adults but not for minors by establishing a consistent age for both tobacco and alcohol. Perhaps most important, since relatively few high school students are friendly with 21-year-olds (though many know 18-year-olds), this could dramatically reduce access to tobacco products for high school students.

6. Student smoking should be prohibited in schools.

7. Tobacco prices should be increased by means of taxation because young people are price sensitive in their demand for tobacco products. Ideally, revenue generated by increased taxes should be used for health education, as has been done with Proposition 99 tax revenues in California.

CONCLUSION

Adolescent tobacco addiction follows a classic economic model. Demand is created by sophisticated tobacco company advertising and promotional campaigns that associate smoking and tobacco chewing with the healthy, glamorous, and athletic lifestyles that many young people aspire to. Free samples, vending machines, and nearly unrestricted over-the-counter sales assure that there is a readily available supply to meet this demand.

The goal of a tobacco-free generation will depend upon success in preventing young people from gaining access to, and as a result becoming addicted to, tobacco products. It will take changes in the laws, and changes in public attitudes.

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STAT

MODEL LEGISLATION

AN ACT TO PROTECT MINORS FROM THE ILLEGAL SALE OF TOBACCO PRODUCTS

The intent of this legislation is to prevent children and young people from smoking and using other tobacco products in order to protect their future health and welfare.

Whereas:

1. Approximately 390,000 Americans die each year of diseases caused by cigarette smoking;

2. The U.S. Surgeon General has determined that smoking is the leading cause of preventable death in this country;

3. The nicotine in tobacco has been found to be a powerfully addictive drug, and it is therefor important to prevent young people from using the substance until they are mature and capable of making an informed and rational decision.

4. Most adults who smoke would like to quit, and a majority of current adult smokers have tried without success, and half of all teenagers who have been smoking for five years have made at least one serious but unsuccessful attempt to quit;

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5. Every day, approximately 5,000 minors under the age of 18 begin smoking;

6. Sixty percent of smokers begin by the age of 14, and 90 percent start before the age of 20;

7. Minors under the age of 18 spend more than one billion dollars on cigarettes and other tobacco products every year;

8. Tobacco is a gateway drug that can lead to the use of alcohol and illicit drugs;

9. There is a significant correlation between smoking and both poor academic and athletic performance among young people;

11. The economic costs of smoking imposed on our society exceed 65 billion dollars each year; and

12. Smoking by young women who are pregnant is a major cause of infant injury and death.

THEREFORE BE IT RESOLVED THAT:

SECTION I: AGAINST THE LAW TO SELL TOBACCO TO MINORS

1. It shall be a violation of this law for any store or merchant to sell, either over-the-counter or through a vending machine, cigarettes or any other tobacco product to any person under the age of 18. It is the duty of the merchant or the merchant's employees to verify the age of prospective purchasers of cigarettes or other tobacco products to assure that they are 18 years old or older. A valid current driver's license shall be sufficient to determine proof. (Note: In states where there is not a photograph on the driver's license, picture identification should be required.)

2. It is the duty of each merchant who sells tobacco to assure that the employees of that store are educated about the law and the importance of obeying it.

3. Every store that sells cigarettes or other tobacco products to minors must post signs that are conspicuously visible to all customers at or near locations where tobacco products are displayed, and at each cash register, reading:

IT IS A VIOLATION OF THE LAW FOR CIGARETTES OR OTHER TOBACCO PRODUCTS TO BE SOLD TO ANY PERSON UNDER THE AGE OF 18.

These signs must be made with red lettering at least one-half inch high on a white background. They must include a graphic drawing of a pack of cigarettes with a circle and cross over it. Signs are available at no cost through the Health Department.

SECTION II: LICENSE REQUIRED TO SELL TOBACCO PRODUCTS

1. Every merchant who sells cigarettes or other tobacco products shall be required to obtain a license. That license may be suspended or revoked for repeated violations of this law, based upon the following schedule:

First Violation: $500 fine
Second Violation: $1,000 fine and 30-90 day suspension of license
Third Violation: $1,000 fine and 6-18 month suspension of license

Each sale of cigarettes or other tobacco products to a minor shall be considered a separate violation.

2. Any merchant applying for a license to sell cigarettes or other tobacco products shall pay a fee of ($300). Once approved, the license shall be valid for a period of (three)

years. Fee revenues shall be used to support the cost of administration, enforcement, and juvenile smoking prevention and cessation.

SECTION III: CERTAIN FORMS OF DISTRIBUTION PROHIBITED

1. It shall be a violation of this law to sell cigarettes in any form except original factory-wrapped packages. The sale of single cigarettes is specifically prohibited.

2. It shall be a violation of this law for any person or organization to give-away, hand-out, or otherwise distribute free samples of cigarettes or other tobacco products, or coupons that can be redeemed for free samples of cigarettes or other tobacco products, anywhere within the jurisdiction. Any person or organization violating this provision shall be subject to a fine not to exceed $1,000 and/or imprisonment of up to 30 days. This provision shall not apply to coupons in magazines published outside of this jurisdiction and distributed within the jurisdiction.

3. It shall be a violation of this law for any merchant, with or without a license, to sell cigarettes or other tobacco products through a vending machine.

3 (alt). It shall be a violation of this law for any merchant, with or without a license, to sell cigarettes or other tobacco products through a vending machine except where said vending machine is equipped with an electronic or manual device which renders the machine inoperable until it is activated by an adult employee upon verification that the prospective buyer is of legal age.

SECTION IV: ENFORCEMENT

1. Representatives of the Health Department (alternatively City Manager or Police Department) are authorized to escort minors under the age of 18 to stores in order to attempt to purchase cigarettes or other tobacco products to test merchant compliance with the provisions of this law. Under supervision from the outside, such minors may enter the store and attempt to purchase cigarettes or other tobacco products. If they are successful, they will immediately surrender purchased tobacco products to the Health Department (Police) officer. The Health Department (Police) officer will then issue a citation to the store manager. If a minor under the supervision of an authorized official purchases tobacco in violation of this ordinance resulting in a citation to the merchant, this shall not be considered to be entrapment.

2. Any citizen who witnesses a minor under the age of 18 purchase cigarettes or other tobacco products, or has reason to believe that a store is selling cigarettes or other tobacco products to minors, may file a complaint with the Health (Police) Department. The Health Department Executive (Chief of Police) will assign a police officer to supervise a minor to test that store's compliance with the provisions of this law, or to notify the store manager of the complaint and inform the manager that subsequent complaints will result in unannounced tests to determine compliance.

3. An adult may escort a minor to retail outlets in order to monitor compliance with this law. Said adult must first obtain approval from the Health (Police) Department using they prescribed form. Any cigarettes purchased in such compliance tests must be turned over to the Health Department, along with a report documenting the results for each retail outlet tested. Results may not be used as the basis for fines or other punishments, but the Health Department executive (Chief of Police) will conduct an independent investigation in accord with Section IV.1 of this ordinance.

5. Merchants or stores that are fined or have their licenses suspended or revoked may appeal to (the appropriate executive or judicial body).

SECTION V: PURCHASE OR POSSESSION BY MINORS PROHIBITED

1. It shall be a violation of this law for any minor under the age of 18 to purchase cigarettes or other tobacco products, except with direct approval by and under the supervision of a Health Department (Police) officer or other authorized adult as part of an effort to test compliance with the provisions of this law.

2. It shall be illegal for any minor to have in his or her possession any cigarettes or other tobacco product.

3. Minors found attempting to purchase or in possession of cigarettes or other tobacco products may be required to perform between ten and forty hours of community service, and/or participate in an approved smoking cessation or other health education program.

4. No school shall allow any student to possess cigarettes or other tobacco products while on school campus or at any school function, nor shall any school make provisions for students to smoke while on the school campus or at any other school function.

DEFINITIONS:

1. Minor shall be defined as anyone under the age of 18.

2. Vending machine is any device that dispenses cigarettes or other tobacco products.

FOR ADDITIONAL INFORMATION, CONTACT:

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The Movement to Restrict Children's Access to Tobacco in Minnesota

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It is becoming clear that in order to prevent tobacco use, we must include strategies which address the supply side, thus making it more difficult for young people to obtain tobacco. By their own report it appears that teenagers primarily obtain cigarettes from commercial sources rather than friends or family, and so laws which effectively prevent purchase by minors could have a major impact on prevalence of tobacco use in this age group.[1,2] While over forty states have laws which prohibit tobacco sales to young people, these laws are largely unenforced, and so their potential impact is unrealized and unknown.[1,3,4,5]

We have begun a research program at the University of Minnesota to develop community-level policy interventions to reduce children's ability to obtain tobacco, and to evaluate the impact of current policies and policy changes in the area of teenage access to tobacco. The purpose of this paper is to summarize the research findings on availability to tobacco to children, and to describe the local and state activities to prevent the sale of tobacco to minors.

Availability of Cigarettes to Teenagers - Research Results

Because of the need to evaluate the potential of policy changes to reduce children's access to tobacco, and ultimately to reduce the prevalence of youthful tobacco use, we began a community level feasibility study. The purposes of the study were 1) to determine what policy changes communities are willing to implement to reduce children's access to tobacco, and 2) to obtain preliminary information about the impact of policy changes on children's ability to purchase tobacco.

The communities of Hastings (pop. 15,000), Stillwater (pop. 13,000) and White Bear Lake (pop. 25,000) were selected from the Minneapolis - St.Paul metropolitan area for this study. The methods are described in detail elsewhere[6]. Briefly, a list of all licensed tobacco outlets was obtained from the city clerk in each community. Seven boys and seven girls age 12 - 15 were recruited to be confederates in this study. During April and May, 1989, three or four different teenage confederates attempted to buy cigarettes, on different occasions, in each tobacco outlet in each community.

A total of 475 purchase attempts were made at 80 over the counter tobacco outlets and 49 vending machines in the three communities. Attempts were made to purchase cigarettes from every licensed outlet. In these communities the most common type of business selling tobacco over the counter is convenience stores, representing 39% of the over the counter outlets. Vending machines are most often found in restaurants (31%) followed by bars (27%).

The teenage confederates in this study were successful in purchasing cigarettes in 63% of their attempts, as shown in Table 1. This includes 53% of the over the counter attempts and 79% of the attempts at vending machines. Among over the counter attempts, the teenagers were most successful purchasing from gas stations (69%), followed by grocery stores (62%) and convenience stores (56%). From vending machines, these teenagers were most successful when the machines were located in gas stations (100%) and restaurants (89%). Only four over the counter locations and two vending machine locations (5% of the total cigarette outlets in these communities) never sold cigarettes to any of our teenage confederates. This means that 100% of the outlets in Stillwater, and almost 95% of the outlets in Hastings and White Bear Lake sold cigarettes at least once in three or visits by a confederate age 15 or younger.

Our teenage confederates had high success rates in establishments often characterized as adult locations. In this study, bars, liquor stores and private clubs represented 45% of the vending machine locations and 19% of the over the counter locations. The combined purchase success rate for these "adult" vending machine locations was 78%, and for over the counter locations was 47%. Clearly, it is important to control children's access in these locations, and not to assume (or accept the tobacco industry's logic) that these locations have controlled access.

Similarly, restaurants represent 31% of the vending machine locations, and are among the most accessible locations for our teenage confederates. Many of them also have liquor licenses which would place them under exemptions to vending machine control policies as proposed by the tobacco industry.

We initially hypothesized that older teenagers would be more successful at purchasing cigarettes compared to younger teenagers, and that boys would find it easier to purchase than girls. Age was positively associated with success rate for both boys and girls in over the counter sales and for girls in vending machine sales, as shown in Table 2, with the largest difference between the ages of 14 and 15. However there was no difference by age for boys in success rate from vending machines. We were surprised to see that boys were markedly less able to purchase cigarettes compared to girls, especially over the counter. Even the youngest age girls were more successful than the oldest age boys in this study. It appears that sales people are more suspicious of boys, and perhaps more willing to attribute negative motives to young teenage boys than to same age girls.

Prior to the start of the study, the city of White Bear Lake had initiated efforts to inform merchants about the state law regarding cigarette sales to minors, and had warned them of the city's intention to enforce the law. For this reason it was of interest to examine purchase success by city. Our results show that White Bear Lake merchants were no less likely to sell cigarettes to minors than other communities, despite these notifications (59% overall adjusted success compared to 62% for Hastings and 66% for Stillwater).

After the purchase attempts were completed in all communities, the Minnesota legislature passed a law raising the charge for sale to minors from a petty misdemeanor to a gross misdemeanor, which carries a maximum penalty of $3,000 fine and/or one year in jail. This change received a great deal of publicity, and merchant associations attempted to inform their members about this change and their increased liability. The new law went into effect July 1, 1989. In an attempt to measure the short term impact of the change in penalty, a 15 year old girl who had made purchase attempts during April and May at almost all outlets in the three cities, and two 14 year old boys who, between them, had visited all outlets were taken back to the same outlets in the three cities. The second visit occurred during the end of July and beginning of August, 1989. A comparison of purchase success before and after the new penalty went into effect is shown on Table 3. Efforts to purchase cigarettes over the counter after the new penalty were significantly less successful for both male and female confederates. However there was no measurable decline in purchase success

from vending machines over the two time points.

The vast difference in success rates between vending machine locations and over the counter locations, and the lack of responsiveness of vending machine locations to an increase in penalty for sale to minors points to the necessity for controlling this source of cigarettes. The impact of the penalty increase on over the counter sales and previous studies[3] show that sales people do learn, at least over the short term, to distinguish customers by age and not to sell cigarettes to minors. However it seems apparent that employees do not feel similarly responsible for monitoring sales by vending machines, even when the penalty is high. Our study points out that young boys in particular have a difficult time buying cigarettes over the counter - they were successful less than 10% of the time after the increase in penalty. This makes vending machines virtually the only commercially available source of cigarettes for that group, who are at the age when more individuals start smoking than any other.

We found that after the increase in penalty for sale to minors, some merchants made efforts to reduce the likelihood of sale to children. For example, some vending machines were moved further inside the establishment, more signs announcing the law against cigarette sales to minors were posted, and merchants were more likely to ask if the teenager was 18. These efforts were largely ineffective, as others have reported[5]. Education of merchants must emphasize that none of these measures is sufficient to prevent sales to children, and that requiring proof of age is the only effective measure.

In summary, the data presented in this study argue for the importance and the potential efficacy of more stringent and universal controls over the distribution of cigarettes, in order to limit children's access to them. Our study emphasizes the importance of addressing cigarette vending machine sales as an issue separate from over the counter sales, because it appears that vending machines sales cannot be controlled by policies which address over the counter sales. It also argues for a ban on vending machines rather than partial restrictions which exempt some locations because teenagers in our study were able to purchase cigarettes from all categories of locations. Finally, the

short term effectiveness of increasing the penalty for sale of cigarettes to minors has been demonstrated for over the counter sales.

Minnesota Laws Relating to Children's Access and Use of Tobacco, Pre-1990

Minnesota is one of the states with several laws concerning sale, distribution, and use of tobacco which could have an impact on tobacco use by young people. Sale or distribution of tobacco to those under 18 has been prohibited for at least 40 years. In 1989, the Minnesota Legislature increased the penalty for sale to minors to a gross misdemeanor, which carries a maximum penalty of a $3,000 fine and/or a year in jail. Local jurisdictions are authorized (but not required) by state law to license tobacco outlets. Virtually all exercise that option, with annual fees ranging from $12 to $50. At least 36 communities include in their licensing ordinance a provision for suspending or revoking tobacco licenses if the licensee sells tobacco to minors. All free distribution of tobacco products has been prohibited by the cities of Minneapolis and St. Paul since 1979, and by the state of Minnesota since 1987. The Minnesota cigarette excise tax is one of the nation's highest at 38¢ per pack, with the last increase (15¢) occurring in 1987. Use of all tobacco products by minors has been prohibited by state law for many years. Recently that law has been taken more seriously by Minnesota school districts - since 1986, approximately 90% of the districts have adopted tobacco free policies which apply to students, staff, and visitors alike. With the exception of the tobacco-free school policies, very few of the laws to limit minors' access or use are routinely enforced.

Recent Action to Limit Children's Ability to Purchase Cigarettes

1. White Bear Lake

Following the collection of the baseline data reported above, the intervention phase of the feasibility study was begin in White Bear Lake and Hastings, with Stillwater designated as the no-treatment comparison. A community organization process was begun to identify residents with a particular interest in children and/or tobacco use, and to involve them in a community task force. Project staff began by contacting people known to us in the communities, and then we followed up on successive referrals over a period of about two months. In both communities we arranged to present an overview of the problem of teenage access to tobacco and a summary of the community-

specific baseline data at a weekly Rotary Club meeting. These presentations served as an introduction to some key leaders in the community, generated referral to other important leaders, introduced us to the local press, and at least in White Bear Lake, gave an important civic group a sense of ownership in the project.

In White Bear Lake the first meeting of the community task force was held in July, 1989. The White Bear Lake task force included representatives of key sectors in the community. The police chief, who had been involved in several youth-related tobacco control activities, was our first member of the task force. A city council member became involved early in the process, and introduced us to the president of the school board, who joined us also. The Rotary Club produced several owners of local businesses, including those which sold tobacco, who provided legitimacy within various sectors of the business community. The local chamber of commerce became part of the task force, and were very supportive of the effort to reduce youth access via merchant education. Several parents of teenagers became active also, as did several members of the local American Association of University Women. The assistant volunteer fire chief provided a location for the meetings.

During the initial meetings, members were given more details about the availability of cigarettes to teenagers in their communities. (Purchase success was reported by category of business rather than for individual businesses, in part to meet the terms of the University of Minnesota Human Subjects Committee.) Starting with a list of possible legal and voluntary remedies drawn up by the study, shown in Table 4, the task force brainstormed possible ways to address the problem of youth access to tobacco. They felt strongly that their first action should be working with merchants to elicit voluntary compliance with the law. However it became obvious that vending machines were an obstacle to encouraging over the counter restrictions on sale, and vending machines became the focus of action. The city staff were contacted to draft an ordinance totally banning cigarette vending machines, and the city council member on the teenage tobacco access task force introduced the ordinance in September, 1989. The task force members each committed themselves to contacting their city council members in support of the ordinance, and to recruiting friends and neighbors to do the same. The city council was given a copy of the summary data describing

availability of cigarettes to teenagers in White Bear Lake. The public hearing was scheduled for the October 10, 1989 council meeting, with the final vote to be taken also that evening. Task force members spoke at the hearing, including the president of the school board who presented a resolution from the school board in support of the ordinance, and the representative of the volunteer fire department, also indicating his organization's support. Representatives from the student council of the high school, of local voluntary health agencies, and concerned citizens also voiced their enthusiasm for the ordinance. The only person to speak against the ordinance in the hearing at White Bear Lake was the legal counsel for the Minnesota Automatic Merchandising Council, whose members include vending machine manufacturers, suppliers and operators. The city council passed the ordinance by a 4-1 vote, after an articulate summation of the issue by the mayor, who indicated his strong support, even though a smoker, for the ordinance.

Thus, as of January 1, 1990 all cigarette vending machines were removed from White Bear Lake, making it the first community in the nation to totally ban that means of distribution of tobacco. Their action drew statewide and national attention, with major wire services reporting their story. Community leaders were aware before the ordinance passed that theirs might be the only city nationally to take that action, and they were happy to be recognized for their leadership role. In particular the mayor and the city council member who introduced the ordinance became articulate and knowledgeable spokespersons for the movement to ban cigarette vending machines. They were the focus of radio and television talk shows nationally and statewide and feature articles in national publications.

2. Other Minnesota Communities

Virtually as soon as White Bear Lake took action, other communities began to consider similar ordinances. On October 27, city councilmembers in both Minneapolis and St. Paul announced their intention to introduce vending machine restrictions. By the end of November, 1989, two more communities had passed total vending machine bans, and two communities had adopted serious restrictions on where vending machines could be located. It was clear that this was an idea that generated considerable interest and support among local government officials and community members, evidencing an apparent readiness to endorse stronger tobacco control measures.

The movement to consider restrictive ordinances appears to have come from various sectors in various cities. In two of the largest, Bloomington and St. Cloud, the community advisory board of the local health department worked with city council members to introduce the ordinance. In other communities city council members brought the issue up initially, and in others (Duluth and Rochester, for example) the Parent-Teacher Association requested that the ordinance be drafted. In some cities concerned citizens acted as individuals to ask their city council to consider an ordinance. Regardless of who took the initiative, identifying a key advocate on the city council appeared to be essential. Someone on the city council had to take the lead in developing the support for the issue among other councilmembers.

The desire to take action was not uniform and some cities, most notably Hastings, our second intervention site, have been unresponsive. One factor, unknown to us at the start of the study, is that the long-time mayor of the city is part of a family which owns all the cigarette vending machines in the city. Her style of leadership has effectively stifled any action on teenage access to date. In another metro area community, a city council member's family owns a local vending machine company, at least partially accounting for the lack of action by that community. It appears that connections to the tobacco distribution industry by local government officials might be a factor in lack of action by some communities.

In order to get more systematic information about the response of local governments to the interest generated by the White Bear Lake ban, a telephone survey was conducted from March 5 - April 5, 1990. Included in the sample were all Minnesota cities of population $\geq$2,000, or 210 cities representing about 25% of the cities in the state. The interviews were conducted by professional telephone interviewers from the University of Minnesota with one individual in each city government. That person was most often the city administrator or city manager (70%), but was sometimes the mayor (23%) or the city clerk (19%). Questions were asked about a variety of ordinances which are available to cities which might limit children's access to tobacco. Respondents were asked whether each ordinance had ever been considered in that community, and details were collected about the action on the ordinance. Questions were also included concerning

efforts to enforce the current laws regarding minors and tobacco, and any other efforts of that community to restrict young people's ability to obtain tobacco. In addition a copy of any relevant ordinance was obtained from the city. Information from two communities which have taken action since the end of the survey are included, for a total of N of 212.

We found that 37 Minnesota communities, or 17.4% of those of population ≥2,000, have passed ordinances restricting cigarette vending machine sales, with 36 of them adopting ordinances from October, 1989 to May, 1990. As shown in Table 5, about half of the ordinances passed are total bans, and those 18 communities include five of the top ten cities in the state by population. About a third (12) of the ordinances are partial restrictions which either exempt some locations, specify where vending machines are not permitted, and/or require locking devices on some or all of the remaining machines. Communities in this category include Minneapolis, St. Paul and Duluth, the top three communities by population in the state. The remaining seven ordinances specify that the machines must be under supervision or within view of employees. Most of the cities adopting ordinances are within a 60 mile radius of the Minneapolis-St. Paul metropolitan area. Communities close to the metro area reported the highest rate of ordinances, and those more than 120 miles away from the metro area were the least likely to adopt any ordinance. Table 6 shows that most of the ordinances have been passed in cities of population ≥10,000. The rate of adoption of total and partial restrictions is positively associated with city size, but smaller communities are more likely to require supervision of machines as a way of controlling minor's access.

We found that a surprising number of city councils have considered total bans on cigarette vending machines (29%, or 60 of the cities surveyed) (see Table 7). These proposals were formally defeated or informally rejected by only 17 city councils, leaving at least 25 governments still interested in taking action beyond the 18 which already have adopted total bans. Similarly about 35 cities remain interested in some level of partial restriction.

We were also surprised to discover that 36 communities (17% of those surveyed) already have provisions in their licensing ordinances to suspend or revoke tobacco licenses if the vendor is caught selling tobacco to minors (Table 8). Almost half of these ordinances are in the smallest

cities in the survey, and all but one of these ordinances was passed during the late 1930's - early 1940's. There are no indications that these penalties are being applied.

Other ordinances which have been passed by at least one Minnesota city to limit minors' ability to purchase cigarettes include: requiring that licensees post a bond which would be forfeited if found selling tobacco to minors (one city); requiring that cigarettes be sold from behind the counter (two cities); and fining minors who are found purchasing tobacco (five cities).

About 58 of the cities surveyed (38%) report current efforts to enforce the state law prohibiting tobacco sales to minors (Table 9). Eleven cities, mostly in the smallest size category, report active enforcement of the state law. The most often reported effort is education of merchants or formal notification of merchants regarding the state law (38 cities, 18%). Other efforts include posting signs, and requesting voluntary action by merchants such as voluntary removal of unsupervised machines.

The most recent example of active enforcement is in the city of Minneapolis, where the city licensing department cited eight establishments for selling tobacco to a teenage confederate. The city council has decided to adopt a three-tier penalty system, with the first offense resulted in a three-day license suspension, the second offense bringing a 30-day suspension, and a third offense resulting in loss of tobacco license.

The White Bear Lake task force has developed and implemented an aggressive model of merchant education which appears to have produced significant results (see below). With University of Minnesota staff assistance, they designed window decals, large buttons for salespeople to wear, laminated signs stating the state law, and a brochure outlining the procedures and rationale for asking for age identification. The task force raised the money to pay for the materials, and hand delivered them with an explanation to each over the counter tobacco license holder in the city. Task force members also made follow-up calls on merchants to reinforce the message.

3.Role of Tobacco Control Activists

Communities interested in taking action on this issue were assisted by several groups. The university research group testified at numerous city council hearings, and offered advice to many communities over the phone. We also put together fact sheets and a written summary of research results that were mailed in response to requests for more information. The city of White Bear Lake estimated that about 250 calls were received from around the state and the nation for copies of their ordinances.

The existing and experienced network of tobacco control activists was crucial to the spread of the ordinances in Minnesota. Local tobacco control advocacy groups, led by the Association for Nonsmokers-Minnesota (ANSR), testified at hearings, helped communities organize their strategy and their testimony, helped communities collect local data on purchase success, and organized media events. ANSR, in conjunction with the University of Minnesota research group, organized a series of six workshops held from December to May, 1989-90 to train local government officials and community activists about how to get address teenage access to tobacco in their communities. The information packets developed for these workshops were sent on request to many cities which did not attend the workshops. The Coalition for a Smoke-Free 2000 called on member organizations such as the American Cancer Society and the American Lung Associations to mail action alerts to their volunteers to encourage them to initiate or support vending machine bans in their communities.

4. The Industry Response

While White Bear Lake's action caught both the vending machine industry and the tobacco industry off-guard, by the end of October they had organized a response. The Minnesota Automatic Merchandising Council's (MAMC's) initial response to the White Bear Lake ordinance was to propose a partial ban which would "require the removal of vending machines from public places where minors have access to the machines while allowing [them] to remain in bars, taverns, cocktail lounges where minors do not have access to such machines" (letter from Thomas Briant, attorney for MAMC, to Joan Niemec, Minneapolis City Councilmember, 10/23/89).

As it became apparent that more, and especially larger, cities were going to consider total bans, MAMC joined with four other Minnesota trade association involved in the tobacco, liquor or entertainment industry to form an organization called the Coalition for Responsible Vending Sales (CRVS). Early news stories reported that the Tobacco Institute was a partner in the CRVS, and included quotes from Gary Miller, spokesperson for the Tobacco Institute[7]. However local spokespersons for CRVS in later months denied that the tobacco industry was involved in the coalition.

The CRVS strategy was basically fourfold. First, in mailings to cities and at local ordinance hearings, they used results from a 1989 study commissioned by the National Automatic Merchandising Council (see Appendix A for executive summary) to discredit research done by our group at the University of Minnesota, and to discount our results showing that over half of tenth graders in our study list vending machines as a major source of cigarettes[2]. Second, they suggested to city councils that they delay action or defeat the proposed ordinance, because CRVS intended to sponsor statewide legislation in the upcoming legislative session which would provide uniform standards for the whole state, and end the "hodgepodge of local laws". This strategy was immediately recognized as a classic preemption strategy which has worked so well at the state level for the tobacco industry[8]. Third, if the city council still wanted to take action, they were encouraged to adopt a compromise ordinance significantly weaker than the compromise originally proposed by the MAMC, as described above. The new compromise started out as simply requiring vending machines to be placed under supervision, and was reborn when the first was rejected as a combination of supervision, locking devices, and exemptions for businesses with liquor licenses. Fourth, they suggested to city councils that they had discovered an unfair loophole in the state law, namely that minors were not prohibited from purchasing tobacco while those who sold tobacco to minors are liable, and that city councils should take action to make minors liable. This proposal had instinctive appeal to many local government officials, allowing them to overlook obvious problems in enforcement, and the fact that the whole movement to limit youth access had begun in this state as a result of demonstrating how easily minors could purchase cigarettes. That data would be much more difficult to collect if minors were prohibited from buying tobacco.

Locking devices became a key industry alternative to proposals to ban cigarette vending machines. A local vending machine manufacturer developed a prototype which claimed to be foolproof. The prototype consisted of a vending machine wired to a remote button and bell mechanism. When quarters were inserted, the bell sounded, the button was lighted, and the levers could not be pulled until the machine was activated by someone pressing the button, thus allowing the transaction to be completed. The prototype required the button to be pressed each time a purchase was attempted, and if the button was depressed (ie. taped open) or the device unplugged before the quarters were inserted, no purchase could be made. The company is marketing the device, which is only usable on electronic machines, for about $150, and indicating that it can be installed by the vending machine owner.

Tobacco control advocates have generally opposed the locking device alternative because it is untested except in Utah, where the state law requiring such devices was found to be ineffective and was repealed, and in small communities, such as Woodridge, Illinois, with very small numbers of machines. Another theoretical argument against the devices is that they require no face-to-face interaction with an employee, and in fact the employee doesn't even have to see who is purchasing before pressing the button. It has been suggested that most busy employees would soon begin to respond automatically rather than interrupting their other duties to check age identification. Also, the demonstrated prototype clearly would not be the only locking device on the market, and there were no assurances that others would be as difficult to disable.

The CRVS organized local vending machine operators and distributors to appear at city council meetings and testify that a total ban would cause financial hardship for them, and/or that their establishments do not sell tobacco to minors. Having children who purchased cigarettes in that community testify about their successes was an important tactic, and usually discounted any claims by businesses that they had voluntarily solved the problem. Interestingly, people who smoke never appeared at local hearings to testify against the ordinances, but some who happened to be in the audience for other reasons testified on behalf of vending machine bans. City councils frequently noted that the only opposition was from individuals whose motivation for speaking

against the ordinance was economic.

The CRVS also tried to convince city councils that the true motivation of the health advocates was to prohibit smoking entirely, that teenagers who want cigarettes will get them anyway, and that they were sincere in their desire not to see children get cigarettes or smoke. We countered with the arguments that this was entirely a children's issue, because those adults who smoke have many other, cheaper sources, and that our efforts were aimed at preventing young children from starting to smoke.

5. Action at the State Level - The Attempt to Preempt

As the CRVS had suggested, they found House and Senate authors for an industry-sponsored bill addressing cigarette vending machines. Their version exempted machines from any regulation which were located in a factory, business, office, or other place not open to the general public; required machines in off- and on-sale liquor establishments to be placed within view of an employee; required all other machines to controlled by locking devices. The final clause preempted local ordinances more restrictive than the state law would be if this version passed. At the point that the legislation was introduced, about 20 cities were known to have passed ordinances more restrictive than the language in the industry-sponsored bill.

The chief author for the House bill was the powerful chair of the Education Committee, whose district included a vending machine business run by a politically powerful individual. In the Senate, the chair of the Commerce Committee, where the bill would be heard, was scheduled to introduce the bill until a major city in his district, Duluth, passed a very restrictive ordinance. The bill was introduced instead by the committee vice chair. Despite the fact that the 1990 legislative session would be short and was primarily to resolve budget issues, sponsors of both bills were promised hearings in the respective Commerce Committees.

The health advocates took the threat of preemption very seriously. All of the state health groups which work on or have an interest in tobacco policy issues, including voluntary agencies, professional organizations, the Minnesota Departments of Health and Education, the University of

Minnesota School of Public Health, major insurance companies and health maintenance organizations, have representatives on the Minnesota Coalition for a Smoke-Free 2000. The Legislative Affairs Committee of that organization became the major strategizing group for the effort to kill the industry bill. We decided that the industry bill would be the only issue the Coalition would work on during the 1990 session. Further, we decided that the primary focus of the attack would be on the issue of preemption. It was not thought fruitful to argue the merits of the bill otherwise, or to debate the issue of vending machine restrictions or tobacco access more generally. We focused on the abridgement of local control which the preemption represented, and that this bill was a tobacco industry bill. When the issue of compromise came up, we decided together that there would be no compromise on the issue of preemption. Anything short of killing that clause was unacceptable. Because of the five-year history of the Coalition, and the successes the member organizations had experienced at the state legislature by working together, the health lobby was able to stay completely united in the primacy of that goal.

Because the issue was framed as one of local control, we were able to generate support from outside the Coalition. The League of Minnesota Cities is well respected by legislators, and worked with us against the preemption clause. The local control issue was attractive to Republican members of the legislature also, and so we were able to draw on some unexpected support.

The industry was represented by individuals with a great deal of power and influence at the legislature. A key public relations figure well known to the legislators was a constant presence. Health advocates recognized from other battles local and national lobbyists and other representatives of the tobacco and alcohol industry. Locally the industry used a law firm as lobbyists whose members have been Democratic legislators or key aids to past state Democratic administrations.

One industry strategy was to frame the issue as one of jobs. They claimed 275 jobs would be lost statewide if local restrictions were allowed to continue. At the legislative hearings they brought in uniformed vending machine route drivers who spoke of their financial obligations and families which would be affected if their jobs were lost. However they were only able to find one person

who could testify that he had already lost his job as a result of the many ordinances which had been passed at that point. We argued that selling the same number of cigarettes in person compared to by machine was likely to create jobs, not destroy them.

An argument attractive to legislators from rural areas was that the smaller towns in their districts were unlikely to pass ordinances, and that the state bill was better than nothing. The industry also argued for statewide uniformity, that it would be too hard to do business with many different ordinances in adjacent communities. The League of Minnesota Cities pointed out that we don't have statewide uniformity in many areas, including liquor control, and that there were no compelling arguments in favor of uniformity in the case of tobacco.

The tobacco control advocates drew on their years of experience with other legislative issues to educate Commerce Committee members and allies in the legislature about the dangers of preemption. Many person-hours were spent at the Capitol in conversation with individual legislators. Considerable time was also spent in organizing telephone and letter-writing campaigns to legislators, especially from individuals in Commerce Committee members' districts.

Probably the group most influential against preemption were the city councilmembers, mayors, and community activists from the cities where restrictive ordinances or total bans had already been passed or were under consideration. Led by the mayor of White Bear Lake, these individuals participated in a press conference at the legislature the week of the House Commerce Committee hearings and lobbied their legislators, many of whom they knew personally. They very articulately relayed the level of thought and study that had gone into adopting these local ordinances, their sincere concern for children which had motivated their actions, and their outrage that the legislature might presume to know better than they what was good for their communities. They were a group of individuals totally activated on this issue, and they were the chief spokespeople against preemption at the hearings. Signs were made from each community which had passed an ordinance and representatives from those communities were very visible in the audience during the hearings.

The other key strategic group were children who had participated in purchase attempt studies. They testified about the ease with which they had purchased cigarettes, and how strongly they felt that something should be done to protect their peers. While they testified in the Senate Commerce Committee, hundreds of packs of cigarettes purchased by children in our studies were unloaded on the table. The symbolic value of their testimony can't be overestimated.

The House Commerce Committee hearings were held first, and the bill was passed out of the committee, after defeat of a bipartisan-sponsored amendment to delete the preemption clause. The loss was no surprise, because the House Commerce Committee was known to be unfriendly. However the loss required us to redouble our efforts, especially in contacting constituents of key Senate committee members. The issue of compromise arose again after the House committee loss, primarily the possibility of grandfathering in the communities which had already passed ordinances, so they would be excluded from the preemption, or attaching a sunset clause to the preemption, so that in two years communities could pass once again more restrictive ordinances. Both of these compromises were rejected by the tobacco control group, who recognized the first as a bald attempt to defuse the opposition from communities with ordinances. The community leaders also rejected that compromise without hesitation.

The Senate Commerce Committee included several powerful members who have been legislative leaders in tobacco control issues in the past. At the hearing they felt confident enough to reject the idea of amending the bill, and to try to kill it altogether by tabling it. The vote to table passed, and preemption was dealt a fatal blow. However, to our surprise, the bill itself resurfaced without the preemption clause, was passed in both the House and Senate, and signed into law by the governor on April 9, 1990.

Our preference would have been to not have had any legislation short of a total ban come out of the legislature. However since we had not fought the provisions of the bill other than preemption earlier, we were unable to do so after preemption had been removed. Our fear, and the tobacco industry's hope, is that the weak state law will serve as a de facto ceiling rather than a floor for communities which have not acted yet.

6. The Role of the Media

From the beginning of this project we have made deliberate attempts to involve the media, particularly newspapers, in the issue. University research staff called the attention of the local press to the groundbreaking nature of White Bear Lake's action, and we called reporters every time a new ordinance was passed. The press responded with a great deal of interest to the issue, and their sympathies with our side of the story grew as the issue developed a David vs. Goliath flavor. Newspaper columnists were especially effective in making public the tactics of the industry, and calling public officials to task who seemed to be bowing to industry pressure. Altogether the two major metropolitan daily newspapers published over sixty articles, editorials, columns, and editorial cartoons on the issue of teenage access to tobacco during the past seven months. A number of letters to the editor and opinion pieces were also published (see Appendix B for examples). During the preemption battle at the legislature, several of those pieces were at our specific suggestion. The effectiveness of the tobacco control advocates with the press was in part due once again to experience with previous issues, and to deliberate cultivation of specific reporters by giving them exclusive information. ANSR in particular also had much experience with press conferences, and they were used to good advantage.

The broadcast media also reported new ordinances as they were passed, and on at least two occasions the local television news programs included features on the issue of teenage access to tobacco. The issue was pursued in depth by the regional cable television stations, with each of them devoting a talk show program to the issue.

7. Implementation

Many of the ordinances have just gone into effect, or won't be effective until a later date, so we have little information on implementation.Total bans on cigarette vending machines obviously are the easiest ordinances to enforce, and indications are that businesses are complying with the law. The variety of new ordinances gives us an extraordinary opportunity to compare effectiveness of the variations on total bans, partial restrictions, and locking devices in limiting access. The University of Minnesota research group will be collecting data on the response of tobacco vendors

to local policy changes; the effectiveness of locking devices in various types of outlets, especially in St. Paul where all locations are required to install them and no locations are prohibited; comparing compliance with the state law and ordinances in local communities; and measuring the impact of these cigarette-focused policies on availability of smokeless-tobacco.

Preliminary follow-up data on purchase success is shown on Table 10 for two of the three communities in the baseline sample (Hastings, with no ordinance, and White Bear Lake, with total vending machine ban plus aggressive merchant education) plus two additional communities, one with a total cigarette vending machine ban (Brooklyn Center) and one requiring vending machines to be placed under supervision (New Brighton). The new ordinances in Brooklyn Center and New Brighton have been in effect since April 1, 1990, and in White Bear Lake since January 1, 1990. These early follow-up data show that White Bear Lake has been the most successful in reducing ability of teenagers to buy cigarettes, with a decline over a one-year period from 83% to 26%. Hastings has shown no decline, and the weak ordinance in New Brighton has not been effective in limiting access. Brooklyn Center has shows an overall lower rate of access due to the elimination of vending machines. However some spillover effect influencing over the counter sales, since the rate of success over the counter is lower than for other communities except White Bear Lake.

8. What Next?

The most urgent challenge for the local tobacco control advocates is to encourage communities to adopt restrictive ordinances or total vending machine bans before the August 1, 1990 effective date for the weak state law. We believe that it will be difficult to encourage communities to eliminate some or all vending machines after owners have made a financial investment in locking devices. The Coalition for a Smoke-Free 2000 and ANSR are sending information, encouragement, and offers of assistance to all communities which have not yet taken action.

A second priority is to address over the counter availability of tobacco. This issue is addressed in three ways: 1) communities are encouraged to adopt a merchant education strategy similar to that described for White Bear Lake above; 2) communities can adopt new ordinances such as requiring tobacco to be sold behind the counter only, or requiring bonds of all licensees, or providing

administrative revocation of license to sell as penalty for selling to minors; 3) cities can be encouraged to actively enforce the age of sale law by carrying out sting operations and citing merchants found to be selling tobacco to minors.

9. Conclusion

The recent flurry of activity in Minnesota demonstrates that a high level of enthusiasm can be generated for fairly dramatic policy changes in the area of childen's access to tobacco. It appears to be most productive to work for these changes at the local level, and communities appear ready to take a leadership role in this area. Success is possible with relatively small investment of resources; in fact motivated individual citizens can often make the difference. Our experience suggests that a synergistic interaction exists between researchers and activists, and that both working together can have a profound effect on community tobacco policy.

Key factors in successful policy change to limit sales of tobacco to children include: 1) demonstrating children's ability to purchase tobacco locally, with the children who participated in the purchase attempts willing to testify at hearings; 2) maintaining the focus of the policy changes on children, and resisting attempts to label the effort an anti-smoking campaign; 3) involving the media in the issue; 4) developing the support of one or more key advocates among the city council.

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Table 1. Cigarette Purchase Success by Type of Business and Method of Purchase

	Purchase Success*			
	Over the Counter	# of Attempts	Vending Machines	# of Attempts
Restaurants	50%	6	89%	54
Gas Stations	69%	21	100%	8
Convenience Stores	56%	115	____	0
Grocery Stores	62%	44	____	0
Drug Stores	44%	37	____	0
Liquor Stores	47%	44	63%	6
Private Clubs	100%	1	79%	22
Bars	40%	11	79%	45
Other	24%	22	64%	38
TOTAL	53%	301	79%	174

*Adjusted for age and sex of purchaser

Table 2. Cigarette Purchase Success by Age and Gender of Purchaser, and Method of Purchase, April-May 1989

			Purchase Success					
Gender	Age	No. of Children	Over the Counter	# of Attempts	Vending Machine	# of Attempts	Mean*	
Boys	≤ 13 yrs	2	21%	28	74%	27	40%	
	14 yrs	3	21%	63	76%	34	41%	
	15 yrs	2	59%	56	75%	24	65%	
			p<0.001		NS			
	TOTAL		35%	147	75%	85	50%	p<0.004
Girls	≤ 13 yrs	3	65%	54	77%	30	69%	
	14 yrs	3	53%	32	81%	21	63%	
	15 yrs	1	84%	68	89%	38	86%	
			p<0.001		p<0.001			
	TOTAL	14	71%	154	83%	89	75%	p<0.003

*Adjusted for method of purchase

Table 3. Purchase Success Before and After Increased Penalty for Sale to Minors

	Purchase Success					
	Over the Counter	# of Attempts		Vending Machine	# of Attempts	Mean**
April-May, 1989						
15-Year-Old Girl	84%	68		89%	37	86%
14-Year-Old Boys	22%	73		74%	43	41%
TOTAL	53%	141		82%	80	64%
July, 1989						
15-Year-Old Girl	66%	79	p<0.02*	89%	47 NS*	75%
14-Year-Old Boys	9%	78	p<0.03*	70%	46 NS*	32%
TOTAL	38%	157	p<0.02*	80%	93 NS*	53%

*Statistical comparisons are within age-sex category of purchaser, between 2 time points.

**Adjusted for method of purchase

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Table 4. Community Supply-Side Options for Tobacco Use Prevention

1. Support tobacco merchants' voluntary efforts

   - Provide information about state tobacco age of sale law and penalties
   - Organize training for tobacco salespeople
   - Provide signs for employees and for purchasers
   - Publicize merchants' efforts to comply with the law

2. Enforce and strengthen existing laws

   - Make enforcing the tobacco age of sale a priority for police
   - Make compliance with tobacco age of sale law a condition of licensure to sell tobacco, with loss of license a possibility
   - Raise municipal tobacco license fees to cover cost of surveillance
   - Require bond be posted by applicants for tobacco license, which would be forfeited if found to be selling tobacco to minors

3. New ordinances or administrative directives

   - Restrict or prohibit sale of cigarettes through vending machines
   - Establish a minimum age for tobacco salespeople
   - Require a sign with the tobacco age of sale law at point of purchase
   - Require plans for surveillance to be included in zoning approval for new tobacco outlets

4. Restrictions on tobacco advertising

   - Prohibit tobacco advertising on city-owned property
   - Work with local publications to refuse tobacco advertising
   - Solicit local support for counteradvertising

Table 5. Local Restrictions on Cigarette Vending Machines by Population

Level of Restriction**

	Total Ban		Partial		Supervision		None	
Population*	N	%	N	%	N	%	N	%
2,000 - 4,999	4	3.8%	1	1.0%	5	4.9%	93	90.0%
5,000 - 9,999	3	7.3%	2	4.8%	0	—	36	86.0%
10,000 - 49,999	9	15.0%	6	10.0%	2	3.3%	43	72.0%
≥ 50,000	2	25.0%	3	37.5%	0	—	3	37.5%
TOTAL	18	8.5%	12	5.7%	7	3.3%	175	82.6%

*Based on 1980 census

**Definitions:
Total Ban - No sale of cigarettes thought vending machines, or permitted only in private workplace
Partial - Some locations specified where machines not permitted, and/or locking devices required on some or all machines
Supervision - Machines must be within view of employees

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Table 6. Local Restrictions on Cigarette Vending Machines by Distance from Minneapolis-St. Paul Area*

Level of Restriction**

	Total Ban		Partial		Supervision		None	
Distance	N	%	N	%	N	%	N	%
Twin Cities Metro	12	13.0%	6	6.5%	3	3.3%	71	77.2%
≤ 60 miles	3	16.7%	2	11.1%	2	11.1%	11	61.1%
61-120 miles	3	7.5%	2	5.0%	1	2.5%	34	85.0%
> 120 miles	0	—	2	3.2%	1	1.6%	59	95.2%
TOTAL	18	8.5%	12	5.7%	7	3.3%	175	82.6%

*Seven County Metro Area

**Definitions:
Total Ban - No sale of cigarettes thought vending machines, or permitted only in private workplace
Partial - Some locations specified where machines not permitted, and/or locking devices required on some or all machines
Supervision - Machines must be within view of employees

Table 7. Status of Local Ordinances to Restrict Cigarette Vending Machine Sales in Minnesota Cities

A. TOTAL BAN

Was considered	60	(28.6%)
Adopted	18	
Defeated	3	
No action	39	

Reasons for No Action:		
Gathering more information	14	
Waiting for legislature to act	9	
Waiting for other cities to act	6	
Waiting for court action	1	
Discussed and rejected	14	

B. PARTIAL RESTRICTIONS

Was considered	82	(39.1%)
Adopted	20	
Defeated	3	
No action	59	

Reasons for No Action:	
Gathering more information	15
Waiting for legislature to act	16
Waiting for other cities to act	4
Waiting for court action	1
Discussed and rejected	20
Businesses voluntarily removed machines	2

Table 8. Adoption of Other Ordinances by MN Communities, to Prevent Youth from Buying Tobacco

- Revoking or suspending license of vendor if caught selling tobacco to minor

Population Category	N	% of Total
2,000 - 4,999	16	15.7%
5,000 - 9,999	8	19.5%
10,000 - 49,999	11	18.6%
≥ 50,000	1	12.5%
TOTAL:	36	17.1%

- Requiring bond to be posted, which would be forfeited if caught selling tobacco to minor

N	% of Total
1	0.5%

- Requiring that cigarettes be sold behind the counter

N	% of Total
2	1.0%

- Fining minors who purchase tobacco

N	% of Total
5	2.4%

Table 9. Efforts to Enforce the Minnesota Age of Tobacco Sale Law by Size of Community

	Population									
	2,000-4,999		5,000-9,999		10,000-49,999		≥ 50,000		TOTAL	
EFFORTS	N	%	N	%	N	%	N	%	N	%
Education/Notification of Law	19	18.6%	8	19.5%	10	16.7%	1	12.5%	38	18.1%
Signs posted	4	3.9%	1	2.4%	4	6.7%	1	12.5%	10	4.8%
Active enforcement	6	5.9%	1	2.4%	4	6.7%	0	—	11	5.2%
Requesting voluntary compliance	4	3.9%	1	2.4%	1	1.7%	0	—	6	2.9%
Other organizations involved	1	1.0%	0	—	0	—	0	—	1	0.5%
Nothing	70	68.6%	32	78.0%	44	73.3%	6	75.0%	152	72.4%
N	102		41		60		8		210	

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Table 10. Purchase Success at Baseline and Follow-Up, by City[1]

	Percent (%) Success				
	Over the Counter	# of Attempts	Vending Machines	# of Attempts	TOTAL
HASTINGS					
April-May, 1989	73%	11	92%	13	83%
July, 1989	75%	20	86%	21	81%
May, 1990	88%	17	88%	17	88%
STILLWATER					
April-May, 1989	91%	23	91%	11	91%
July, 1989	59%	22	93%	14	72%
May, 1990	[Data Not Available]				
WHITE BEAR LAKE[2]					
April-May, 1989	82%	34	85%	13	83%
July, 1989	65%	37	92%	12	72%
May, 1990	26%	38	--	--	26%
NEW BRIGHTON[3]					
May, 1990	86%	21	86%	7	86%
BROOKLYN CENTER[4]					
May, 1990	45%	22	--	--	45%

[1]Using one 15-year-old girl as confederate
[2]Implemented Total Vending Machine Ban, Jan. 1, 1990
[3]Implemented Partial Restriction, April 1, 1990
[4]Implemented Total Vending Machine Ban, April 1, 1990

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Appendix A

Findings For The Study Of Teenage Cigarette Smoking And Purchasing Behavior

Prepared For:

National Automatic Merchandising Association
20 North Wacker Drive
Chicago, Illinois 60606

Prepared By:

Response Research, Incorporated
500 North Michigan Avenue
Chicago, Illinois 60611

NB 6246
June/July 1989

EXECUTIVE SUMMARY

This study was conducted to determine how and where teenagers who smoke currently obtain their cigarettes. More specifically, this study was done to measure the following:

--the extent to which teenagers obtain cigarettes by purchasing them, and

--the portion of the cigarette purchasing that is done through vending machines.

METHODOLOGY

This was a mall intercept study which surveyed 1015 males and females between the ages of 13 and 17 who smoke cigarettes. The number of teens interviewed from each age group mirrored the 1987 Census Data of the teenage population. Additionally, half of the interviews were conducted with females and half were conducted with males.

In order to obtain a geographically dispersed sample of teens, the study was conducted in twenty cities throughout the U.S.. Two different mall locations were used in each city. One mall was located in an average to above average income area and the other was in an average to below average area. This was done to get the best possible representation of different socioeconomic areas.

OVERALL FINDINGS

This study found that vending machines are not a primary source of cigarettes for teenagers. When teens first start smoking, they rely heavily on their friends for cigarettes. After this initial phase, the main source of cigarettes for teens is an over-the-counter location.

DETAILED FINDINGS

Initial Smoking Behavior

--On average, the teens included in this study started smoking at the age of thirteen. There was not a lot of difference between the males and females as to when they started smoking.

--The teens were asked to express in their own words the reasons why they started smoking. They indicated that the primary motivator was knowing someone else who smoked (58%). This other person was usually a friend (42%). Social pressure also played a role in the teens' trial of cigarettes (30%).

--Friends who smoked were both the main reasons why others started and the main source of cigarettes for these new initiates. Almost three in five of the teens (57%) said that their main source of cigarettes when they first started smoking was their friends. Unlike the others, the teens who started smoking before they were ten years old were equally likely to rely on their friends and on family members for cigarettes.

--Most of the teens who primarily got their cigarettes by purchasing them when they first started smoking bought them over-the-counter (84%) and not from a vending machine (only 16%).

Current Cigarette Consumption

--The teens were asked about their daily and weekly cigarette consumption. On average, these teens smoked half a pack of cigarettes the day before the interview. Additionally, the average male smoked more (11 cigarettes) than the average female (9 cigarettes).

--As can be expected, the younger teens smoked less than the older teens. In fact, the 17 year olds smoked twice as many cigarettes as the 13 year olds (14 cigarettes vs. 7 cigarettes on average).

--The number of cigarettes that the teens reported smoking in the week before the interview was slightly less than seven times their reported daily consumption. On average, the males smoked just over 3 and a half packs (73 cigarettes) and the females had smoked just over two and a half packs (56 cigarettes); while the youngest teens smoked about half as much as the oldest teens (13 year olds--45 cigarettes and 17 year olds--88 cigarettes).

Current Source Of Cigarettes

--While friends were initially the primary source of cigarettes, this is not the case beyond the first phase of smoking. The most frequently used source of cigarettes is to purchase them. Nearly three-quarters of the teens (72%) reported that they bought cigarettes more often than they used other methods of obtaining cigarettes. Furthermore, there was little variation on this measure between males and females. However, the older teens were more likely than the younger ones to buy cigarettes frequently (60% of 13 year olds vs. 85% of 17 year olds). And, very few of the 17 year olds (5%) never buy cigarettes.

--While friends are not the primary source of cigarettes once teens have established their smoking habit, they are an important secondary source. Almost half of the teens (45%) rely on friends occasionally for cigarettes. Friends are of particular importance to the younger teens. Almost four out of five 13 year olds (79%) go to their friends often or occasionally for cigarettes.

--Family members are not a significant source of cigarettes for teens regardless of their age.

Cigarette Purchasing Behavior

--Frequent Purchasers, those who buy cigarettes often or occasionally, rely much more on over-the-counter sources than on vending machines. Almost two-thirds of the Frequent Purchasers (64%) buy over-the-counter often whereas only one in ten (9%) buys from a vending machine often.

--Over-the-counter sources are used more by the older teens than by the younger teens. Over three-quarters of the 17 year olds (78%) buy over-the-counter frequently whereas only half (46%) of the 13 year olds do.

--Those who purchase over-the-counter often or occasionally cited four locations as the ones they go to most frequently: convenience stores (43%), gas stations (29%), grocery stores (11%) and drug stores (6%).

--As mentioned, less than one in ten Frequent Purchaser uses a vending machine often. In fact, over three-quarters of the Frequent Purchasers (78%) seldom or never buy from a vending machine. Of course, this varies by age. The 13 year olds are the most likely to use vending machines (22% do so often) and the 17 year olds are the least likely (2% do so often).

--The primary location of the vending machines used by teens is a restaurant or other eating establishment. Almost half (47%) of those who buy from a vending machine often or occasionally go to a restaurant most often. Bowling alleys (11%) and gas stations (11%) are also popular locations.

--Those who use over-the-counter locations often or occasionally gave their reasons for this usage. There were three main reasons:

. . .they are convenient (31%),

. . .they will sell them to the teens (18%), and

. . .they prefer these locations because they dislike vending machines.

--Those who seldom or never bought over-the-counter did not buy from this source more frequently primarily because they were underage and felt they would be asked for an ID or hassled in some other way (59%).

--Teens who bought from vending machines often or occasionally found this source to be attractive because no one will stop them from buying cigarettes this way (56%).

--The teens who seldom or never bought from vending machines did not buy there because they felt that these machines were not conveniently located (48%).

Difficulties Encountered When Trying To Buy Cigarettes

--The teens who buy cigarettes (often, occasionally or seldom) were asked if they had ever been prevented from buying cigarettes. Three in five of them had, with more 13 year olds having been refused (71%) than 17 year olds (50%).

--Those who had been refused were asked if they had been refused when buying over-the-counter and/or from a vending machine. Virtually all of these teens (98%) had been refused when buying over-the-counter, while about one in ten (11%) had been prevented from buying from a vending machine for a reason other than that the vending machine was broken.

Teen Awareness Of Cigarette Purchasing Laws

--Three-quarters of the teens (76%) were aware of a state law which prohibited certain kinds of people from buying cigarettes. When asked what the law said almost everyone (95%) indicated that it required the residents to be a certain age in order to buy cigarettes.

Parental Awareness And Approval Of Their Teenager's Smoking

--The teens were asked who else in their family smoked. Only 15% said that no one else did. Almost half of the teens had a father and/or mother who smoked (49% and 45%, respectively).

--As a way of determining whether or not their parents were aware of their smoking and approved of it, the teens were asked if they were permitted to smoke at home. Almost two in five teens (38%) were allowed to. The portion of teens who could smoke at home varied by age. Less than a quarter of the 13 year olds (22%) were able to while over half of the 17 year olds (54%) could.

--Additionally, almost half (45%) of the teens were permitted by their parents to purchase cigarettes. This too, varied by the age of the teen. Almost two-thirds (64%) of the 17 year olds were permitted to while only a quarter of the youngest teens could.

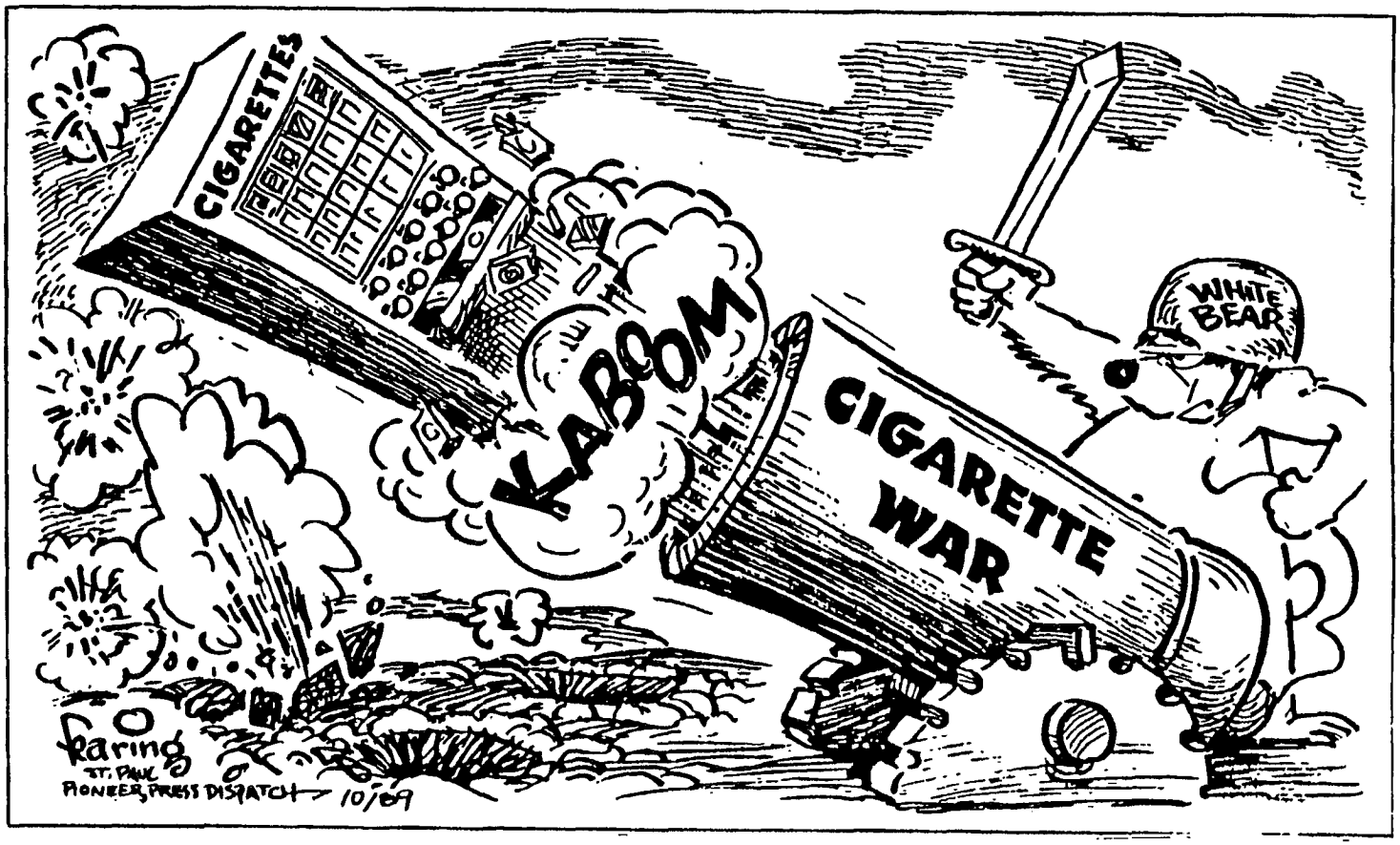
--When asked where they got the money for their cigarettes, three main sources came up: a job (63%), from parents/mom/dad (26%), and from one's allowance (26%). Since the older teens are the most likely to hold jobs, this was their primary source of cigarette money, whereas the younger teens relied more on their allowance and their parents.

Appendix B

Examples of Editorial Cartoons and Editorial Support for Cigarette Vending Machine Restrictions

OPINION

St. Paul Pioneer Press Dispatch
October 12, 1989



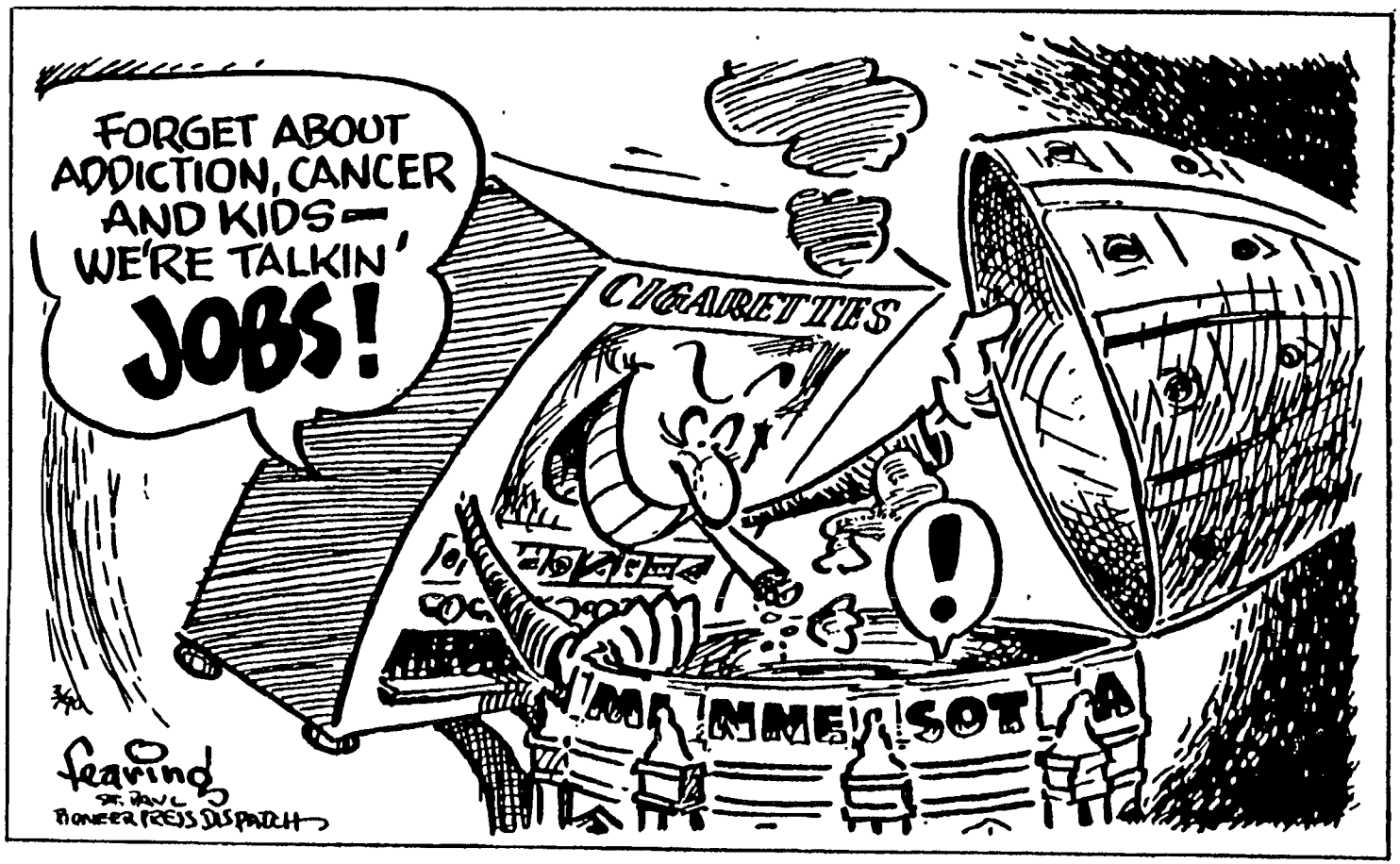
2026172440

St. Paul Pioneer Press Dispatch
October 26, 1989

OPINION

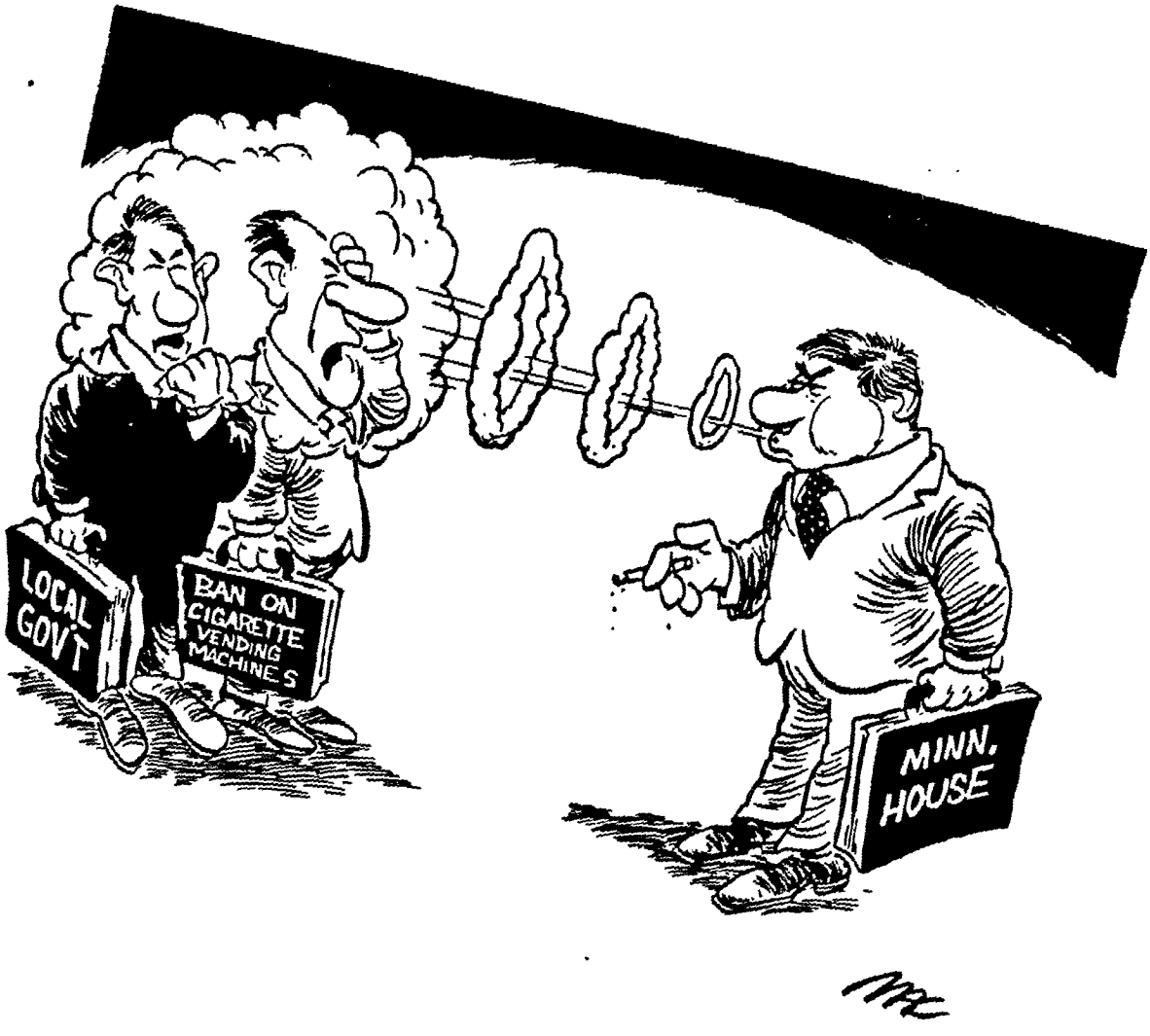
20261724 41

St. Paul Pioneer Press Dispatch
March 8, 1990

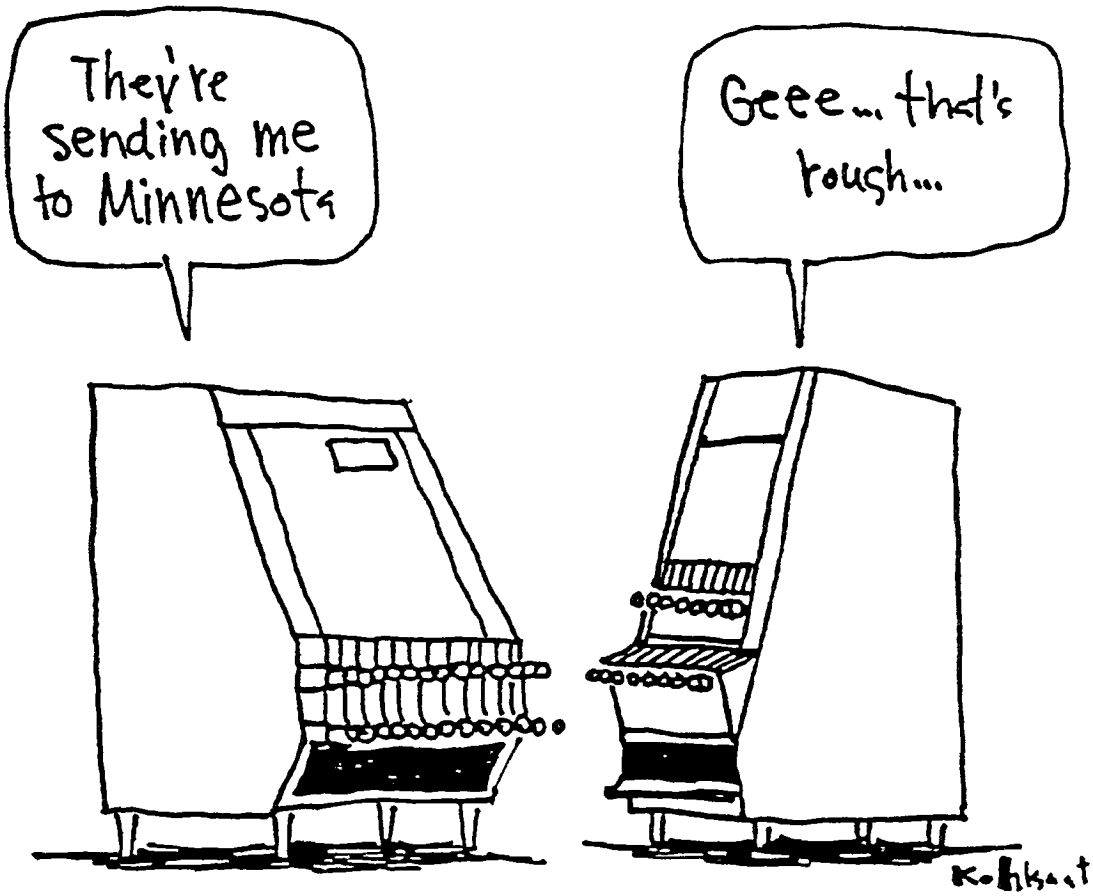


2026172442

Star Tribune
Thursday/March 8/1990



Minneapolis Star Tribune
March 21, 1990



2026172444

Minneapolis Star Tribune October 22, 1989

Doug Grow

A simple law gets ball rolling against smoking

Star Tribune

Saturday
December 9/1989

Jim Klobuchar

Blowing smoke at kids' health

SUNDAY, NOVEMBER 5, 1989

ST. PAUL PIONEER PRESS DISPATCH

KIDS AND SMOKING

Time to say goodbye to cigarette machines

Star Tribune

Tuesday/December 12/1989

For tighter controls on cigarette machines

Star Tribune
February 8/1990

Jim Klobuchar

Smoking out the politicos on tobacco

Minneapolis Star Tribune December 14, 1989
Editorial

Limit access to cigarette machines

Minneapolis Star Tribune

March 8, 1990

Jim Klobuchar

Smoke gets in eyes of legislators

Star Tribune

Thursday/March 8/1990

Let cities adopt stricter smoking laws

Minneapolis Star Tribune
April 1, 1990

Doug Grow

Legislation is lesson in felling giants of tobacco

2026172445

Remarks of Officer Bruce R. Talbot
Woodridge Police Department
DARE Program
Woodridge, Illinois

CONTROLLING ADOLESCENT ACCESS TO TOBACCO: THE WOODRIDGE TOBACCO LICENSE LAW AND DePAUL UNIVERSITY EVALUATION

As a police officer assigned to teach a 17-week drug prevention program to over 1,500 students, I made some startling discoveries. The first is the average age children begin to use cigarettes is now 13 years old, nationwide, but only 12 years old in my community. The next was that nicotine addiction in adolescent smokers is acquired quickly, usually before the child is old enough to legally buy cigarettes. And, sadly, I learned that merchants will not voluntarily stop selling cigarettes to 13-year-old minors, even after a written warning is received from the police.

Finally, I see the issue of 13-year-old children having easy access to large quantities of cigarettes as a serious police matter. Not only do we lose more American lives to nicotine addiction than all other drugs and alcohol combined, but that, for adolescents, cigarettes are "gateway drugs" to illicit drugs such as marijuana and crack cocaine. I firmly believe that we will not make significant progress in the war on drugs until we address the issue of adolescent access, use and addiction to tobacco.

Woodridge, Illinois is addressing this issue with a unique law that has reduced tobacco sales to minors from 83% to zero. But without a national approach, our local efforts may have been for naught, because the merchants whose stores boarder Woodridge continue to sell cigarettes to 13-year-old children 94% of the time.

Let me share with you my experience that lead to our tobacco law and the results of the DePaul University study on the law's effects.

While teaching the Drug Abuse Resistance Education (DARE) program at Jefferson Junior High School, I received complaints from teachers, parents and even the students, themselves, that Woodridge merchants were selling cigarettes to minors. On one occasion, a gym teacher observed a 13-year-old female student purchase a pack of Marlboros from a Mobil Oil gasoline station just two blocks from the school. The teacher reported the occurrence to the principal, as student possession of cigarettes is a violation of school regulations. The principal suspended the girl after calling her to the office and finding the cigarettes in her purse. He then met with me and asked, "Isn't it illegal to sell cigarettes to 13-year-old students? Isn't there something the police can do to stop this?"

Illinois State law, (Chapter 23, Section 2357), prohibits the sale of tobacco products to anyone under the age of 18 years. However, the law was adopted in 1887 and carries a penalty of only $50. That may have been a great deal of money in 1887, but is hardly a deterrent today. The manager of a gasoline station in Woodridge related that he averages between $200 to $400 per day in cigarette sales, making a $50 fine meaningless.

This archaic law contains a loophole big enough to drive a truck load of cigarettes through, and explains why police agencies have never enforced it. The law states that if a minor possesses a written note from a parent or guardian, then the child is exempt from the law regardless—of age!

How is the police officer, or for that matter a reputable merchant, able to verify the authenticity of the note before enforcing the law? And even if the police could check with the parent, most parents would be unlikely to involve their child in a police action over the forged note. After closely examining the old statute, the Chief of Police agreed the law was realistically unenforceable. I have not been able to find even one occasion in the State of Illinois when this law has been enforced.

The Woodridge police response to the principal's complaint was to send a letter to each tobacco-selling merchant from the Chief of Police. The letter related the complaints and advised that tobacco sales to minors under 18 years of age is a criminal offense and runs counter to the anti-drug programs the community had undertaken. The letter closed with a warning that arrests would be made under the State law if repeat violations occurred.

The school approved of the response and the police department felt the matter was closed - until I saw a new report of a study done in Chicago by DePaul University. That study found that 87% of Chicago merchants sold cigarettes to minors in violation of the Illinois 18-year-age limit. I phoned the author, Dr. Leonard A. Jason, and told him we had the same problem and solved it with the police letter. Dr. Jason shot back, "You won't know what effect your letter had on merchant behavior until you scientifically test it."

Of course, he was right. We had hoped our merchants would comply. After all, would an adult really sell cigarettes to a 13-year-old child after being warned by the police? The answer is yes!

Dr. Jason advised us on how to replicate his Chicago study and supervised its execution. Each merchant was approached on three different days and at different times of the day in order to obtain a true sample of different clerks' behavior. The 13-year-old student volunteers were told to wear jeans and sweat shirts. Girls were not allowed to wear jewelry or makeup. Each student was photographed to document their age-appropriate appearance. In all cases, the student would enter the store alone and was instructed to ask for a pack of cigarettes. If asked for their age, they were instructed to say 13 years. I observed the scene from an unmarked police car, and recorded the data after each visit.

The study found that 83% of Woodridge merchants continued to sell cigarettes to 13-year-old minors *after* being warned in writing by the police that such sales violated State law. Given the 87% sales rate in the DePaul/Chicago study where no warning was given, the Woodridge police warning letter had no effect on tobacco sales to minors.

Faced with an unenforceable State law and a continuing violation, I wrote a city ordinance that required a special license to sell tobacco products. The Woodridge tobacco license law is similar to a liquor license, in that sales to minors result in a suspension of the merchant's license to sell tobacco, and a fine of up to $500. Repeat offenders are subject to license revocation.

In addition to the license, the law requires a remote-controlled electronic lock-out device on cigarette vending machines which are accessible to minors. These devices, called "Utah Remotes" in the vending trade, cost under $50 and can be installed in under 30 minutes. Any attempt to defeat the lock-out or release the lock-out for a minor can result in a license suspension and fine. Private cafeterias, such as factories and taverns where minors are prohibited, are exempted from the lock-out requirement.

Furthermore, a sign provided by the City that reads: "THE SALE OF TOBACCO PRODUCTS TO PERSONS UNDER EIGHTEEN YEARS OF AGE IS PROHIBITED BY LAW" in red, one-inch letters on a white background, must be posted at or near every display of tobacco products. This sign requirement was added because of a study reported in the June 26, 1987 issue of the *Journal of the American Medical Association*, entitled, "Legislative Efforts to Protect Children from Tobacco," which found that compliance with State restrictions was highest in stores where a warning sign was posted.

The ordinance also sets a minimum age of 18 years to sell tobacco. This is patterned after the minimum age to sell liquor in Illinois, and recognizes the fact that peer pressure on a younger clerk to sell tobacco to a 17-year-old customer might make it too difficult to say no. This provision has raised the objection of the Illinois Retail Merchants Association who argue that 16- and 17-year-old clerks may lose their jobs if they are not allowed to sell tobacco. So far, this has not been the case.

In addition, free distribution of tobacco products is limited to a licensed merchant's store, and no license or free delivery is permitted within 100 feet of any school, child care facility or other building used for education or recreation programs for children. A May 1987 report from the Department of Health and Human Services recommended such a ban on free samples because "...they inevitably fall into the hands of children." The 100-feet proximity ban mirrors the Illinois State liquor law and backs up the school district ban of tobacco on school grounds. This section would also address an older teen giving cigarettes to a minor at a park or at other gathering points for adolescents.

The final section of the Woodridge tobacco ordinance is the prohibition on possession and attempts to purchase tobacco by minors under 18 years of age. Minors can be cited using a mail-in "parking ticket" with a $25 fine for possession and a $50 fine for attempting to purchase. Police enforcement of this section is similar to the seat belt law, in that officers do not make "sweeps," searching for cigarettes in meeting places for juveniles, but rather use the law when contacting minors for other violations such as curfew or disturbance calls. Although no police arrest record is generated when a ticket is written, the issuing officer does attempt to contact the parent via telephone prior to the end of the watch.

I strongly feel that adolescents must be accountable for their actions. It is unfair to place the entire onus of the law on the merchant. To do so allows the minor to "keep shopping" until a merchant willing to sell is found. This clause also backs up the merchant who might be harassed by underage minors. Now, the merchant can call the police instead of watching the minor walk across the street to his competitor. For this very reason, under Illinois' liquor law, it is a violation for a minor to attempt to purchase liquor.

Adolescents look to adults for guidelines or limits. By not addressing underage possession, society sends a confusing mixed message to minors about use of cigarettes. Illinois' 103-year-old tobacco law is silent on possession by minors, and several students have asked me, "If it's not any good for you, why is it legal for kids to smoke?" Woodridge is one of the few communities where it is not legal for children to smoke or even possess tobacco. This is currently the law in only 12 States.

It is important to understand that the Woodridge tobacco license law is a civil action as opposed to a criminal action. A license action is heard in an informal hearing before the mayor, not in a misdemeanor criminal court with long delays and expensive legal motions. Recently, police in Ramsey, Minnesota made criminal arrests on three working-mother store clerks who sold to a police supervised minor. The public response in the press was very negative and had a chilling effect on further police enforcement. The public response to a civil license action and fine in Woodridge has been overwhelmingly positive. The City has not received a single complaint from either merchants or the public on the enforcement of the ban on sales or possession by minors.

After the tobacco license law was adopted by the city council, merchants were hand-delivered a copy of the ordinance and questions were answered about implementation. The license application was accepted by mail and the fee kept low at $50, which covered printing and administration. Merchants were warned that the police would be using 13-year-old special agents to check compliance with the new age restrictions. Merchants were also given 30 days grace after the law's effective date to train employees and install the vending machine lock-outs. Only one store was unable to complete the installation within the grace period and was granted an additional 30-day waiver.

During each of the following "sting" operations, statistics were recorded for the ongoing DePaul University study. At the same day and time, DePaul research assistants would also test all tobacco-selling merchants that surround but were located just outside the jurisdiction of the Woodridge ordinance, to document what effect the law would have on their sales behavior.

After the first enforcement, 33% of licensed merchants sold to the 13-year-old police special agent. The mayor, serving as liquor and tobacco commissioner, followed past precedent on liquor license actions involving sales to minors, and issued written warnings and no fines.

On the second enforcement, only 10% of merchants sold. These stores, two national chain gasoline stations and one regional chain drug store received a one-day license suspension and a $400 fine. None of the merchants contested the hearing, suspension, or fine.

On the third and fourth stings, none of the merchants sold cigarettes to the 13-year-old police agent, including through vending machines! According to Dr. Leonard A. Jason, supervising the DePaul University study, Woodridge is the first community in the United States to document 100% compliance with tobacco age restrictions.

However, the data from the merchants surrounding but just outside the jurisdiction of the Woodridge tobacco license ordinance were shocking. Despite full page coverage in the *Chicago Tribune* and evening news features from two Chicago television stations, these stores sold to 13-year-old children 94% of the time, usually with no questions asked. It is clear from the data that Woodridge, Illinois has solved only part of its tobacco sales problem. Because of urban sprawl, Woodridge adolescent smokers merely walk across the street to Downers Grove, Darien or Lisle, to buy their cigarettes. Woodridge, of course, has no control over another community's merchants. Thus far, only one of the four neighboring towns has licensed tobacco sales. Downers Grove has resisted adopting a similar ordinance because that city does not issue business licenses, although they do license liquor sales.

In addition to the merchant study, we also conducted anonymous tobacco-use surveys among 650 Jefferson Junior High School students to determine what effect the new law would have on users, and if police/community relations would suffer. The surveys were conducted by the school rather than by the police DARE program to avoid bias, and were done before and after publication of the tobacco license law.

Of the 7th and 8th grade students surveyed, 98% said they knew of the new law banning possession and sales of tobacco to minors; 72% said they thought the law would help prevent them from smoking, and 55% said they though it would deter other students from smoking. Of the 16% of students who claimed to be regular cigarette smokers, 12 years was the average age of first tobacco use; 15% of student smokers were already using a pack of cigarettes a day. Although the students ability to purchase cigarettes in Woodridge dropped dramatically from 83% before the law to a self-reported 39% after the law was adopted, 72% of student smokers reported buying cigarettes from merchants outside the jurisdiction of the Woodridge license law.

In the earlier Chicago study by Dr. Leonard A. Jason of DePaul University, extensive interviews of underage smokers found they obtained their cigarettes 74% of the time from retail merchants. That percentage was further narrowed to 37% from gasoline stations, 23% from food stores, 11% from drug stores, and only 3% from vending machines. The number one reason given by the teens for where they purchased cigarettes was cheapest price. Gasoline stations, in fact, do have the lowest prices for cigarettes while vending machines have the highest prices. Even though these underage smokers can not yet drive a car, they most often walk into a gasoline station to illegally purchase cigarettes. And based on the Woodridge experience, even though there is no car parked at any gas pump, gasoline station attendants often sold cigarettes to 13-year-old police special agents.

In the course of presenting the Woodridge tobacco license law to neighboring communities, (eight of which have adopted similar laws as of May 1990), the technique of using 13-year-old police special agents to test compliance with the age restriction section has been questioned as police entrapment.

The courts have deemed it entrapment when the police force or compel a person to commit a crime. If the police merely provide an opportunity for criminal activity to be observed and documented, then there is no entrapment. If the police agent looks 13 years old, does not present altered identification, and does not offer a compelling plea such as, "My mother just came home from the hospital with a broken leg and sent me to buy her cigarettes," then there is no entrapment. Also, because this is a civil, administrative license hearing, the rules and weight of evidence are different from a criminal trial.

One deficiency in the Woodridge ordinance was discovered recently. While presenting the Woodridge license law to the City of Woodstock in McHenry County, Illinois, I observed a merchant selling loose, unpackaged individual cigarettes for a dime. The cigarettes were in a clear plastic container next to a red plastic bowl of Bazooka-brand bubble gum for a nickel. Although the clerk pleaded ignorance as to the owner's motive, it was clear the display was targeted at the children. Few adult smokers would buy one cigarette for a dime. According to both the State of Illinois Revenue Department and the Federal Bureau of Alcohol, Tobacco and Firearms, such unpackaged sales are not illegal, as long as the original tax was paid and the health warning was displayed somewhere on the container. This practice must be outlawed.

Many people view smoking as an issue of freedom of informed adult choice. Few would argue that the 13-year-old students used in this study possess the knowledge or emotional maturity to make an informed decision on the risks of smoking. However, as we have seen from the Jefferson Junior High School survey and most notably the National Institute on Drug Abuse's National Household Survey on Drug Use, 13 years is now the average age adolescents begin smoking.

Let me emphasize the word "average." I recently received a phone call from Mr. Brent Schendewolf, principal of Lovejoy Elementary School in Alton, Illinois. He discovered a 3rd grade student, 9 years old, with a tin of Hawken ruff cut Wintergreen dipping tobacco. The child said he has been buying it at the Clark gasoline station in front of his school bus stop.

As we have learned from the 1988 Surgeon General's report on the health consequences of smoking, "Cigarettes and other forms of tobacco are addicting...similar to addiction to drugs such as heroin and cocaine." What many people do not realize is the addicting effect on children is just as dramatic. A study by Professor R.T. Ravenhold, of 15-year-olds who smoked as few as five cigarettes per day, found 51% had tried to stop smoking but failed, and 27% said they could not stop smoking no matter how hard they tried.

So when the tobacco industry argues that smoking is a freedom of informed adult choice, in reality the current 13-year-old smoker, or 9-year-old chewer, will have their adult freedom of choice stolen away from them by nicotine addiction.

As a police officer assigned to drug prevention duties in our community's schools, I would like to make a case for controlling cigarette sales because of their use as a "gateway drug" for adolescents. Gateway drugs are drugs of first use that facilitate progression to more dangerous illicit drug use.

Many studies have established a statistical link between adolescent cigarette smoking and the use of illicit drugs like marijuana. The National Institute on Drug Abuse documented such a relationship as early as 1975. Their study, "Predicting Adolescent Drug Abuse," found a strong connection between junior high school student cigarette use and the use of other illicit drugs. Dr. Shapiro, writing in the *International Journal of the Addictions* summarizes: "The data seem to indicate abstinence from one activity, (adolescent cigarette smoking), would inhibit experimentation and possible problems with other substances."

There is a very real physical explanation for this statistical connection. Adolescents are unable to successfully deeply inhale and hold harsh marijuana smoke without first becoming accomplished cigarette smokers. Without cigarettes facilitating or "training" the lungs, adolescents merely cough up the marijuana smoke and are unable to become intoxicated. Without the reward of being high, the student soon loses interest in the substance. In fact, 92% of regular adolescent marijuana smokers are also regular cigarette smokers, according to the National Household Survey on Drug Use.

Thus, what starts as cigarette use and addiction at 13 years of age becomes marijuana use and dependence at 15 years and crack cocaine smoking and addiction at 17 years of age. Rather than waiting to treat crack cocaine addiction with expensive rehabilitation, it makes sense to focus on adolescent drug prevention. According to Dr. Robert DuPont, an authority on juvenile drug abuse: "Prevention of cigarette smoking is a high priority in the prevention of dependence on all drugs."

In the matter of tobacco sales to minors, there is compelling government public health interest in restricting children's access to tobacco products. There is documented evidence from studies conducted in urban, suburban and rural communities across the country that the sale of tobacco is being made to children; and current regulative efforts have proven to be ineffective. It is then reasonable to license merchants so as to enforce age restrictions on the sale, possession and use of tobacco products. The granting of a license is the granting of a public trust, whether it is the operation of a vehicle, the practice of a profession, or the sale of potentially dangerous products. The violation of that public trust by reckless operation of a vehicle, abuse of professional practice or the sale of substances in violation of age restrictions should and must result in the suspension or revocation of that public trust as expressed in that license.

One purpose of government is to protect those in our society who are unable to protect themselves from danger. Certainly the protection of 12- or 13-year-old children from easy access to large quantities of an addicting and known cancer-causing drug should be the responsibility of government.

Until Federal or State governments are willing to address this threat to children, local communities like Woodridge, Illinois will have to regulate tobacco, themselves. Unfortunately, without a national approach to this problem, even the best laws, diligently enforced, can be defeated by neighboring communities and States whose priorities lie elsewhere.

Police officers in Illinois learned that lesson battling drunk-driving deaths. Illinois had lowered the drinking age from 21 to 18 years during the Viet Nam war years. When teen and innocent driving deaths soared, the law was changed back to 21 years of age. But Illinois was unable to stop the senseless deaths because our neighbor to the north, Wisconsin, maintained the lower alcohol age limit. Every weekend, teens from the populous Chicago metropolitan area would drive across the Stateline to legally drink in Wisconsin, and then attempt to drive back to Illinois, drunk. It wasn't until the national age limit of 21 years was imposed on Wisconsin with the threat of Federal highway funds being cut, that Illinois drunk driving deaths were meaningfully reduced.

I believe the 390,000 American lives lost each year to smoking addiction will not be meaningfully reduced until we address the issue of cigarette sales to 13-year-old children on a national basis, using the same carrot-and-stick approach that was successful in drunk driving.

If we are to win the war on drugs, American politicians must become as concerned with nicotine drug sales to children as they are with foreign drug sales to adults.

I hope the Committee can recommend bold and decisive action to quickly address this issue. Everyday, another 3,000 children start using tobacco.

I would be happy to answer any questions the Committee might have.

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Remarks of Edward Greer, Esq.
Kyte vs. Phillip Morris, Incorporated

ILLEGAL SALES TO MINORS: THE ACHILLES HEEL OF THE TOBACCO INDUSTRY

THE CONCEPTUAL BACKGROUND

No one disputes that is wrong to sell cigarettes to minors, and in most States, it is a minor criminal offense to do so. The laws barring such sales are examples of what is known as "protective legislation" because they bar what a class of (weak) persons might do otherwise voluntarily. Historically, such laws prevented both economic exploitation of women and minors and also served to enforce certain types of moral injunctions.

Such legislation has a generally benign character. Its positive side is precisely to protect against extremes of economic or other exploitation in an otherwise untrammeled "free" market society. Children, for instance, are forbidden to exercise the option of working with dangerous machines in factories. What differentiates such "protective legislation" from far more problematic laws that can take on a repressive nature (such as those making criminal the use of drugs) is that they recognize that the person who "freely" chooses the activity is a *victim to be protected,* and not him or herself a criminal. Rather, the onus of criminality is on the more powerful beneficiary of the activity. Thus, child labor laws make the employer who puts the child to work to make a profit the criminal; the child (even if he lies about his age to get the job) is—as the beneficiary of the society decision to protect him and treat him as the victim—never punished for his participation in the wrong.

When we apply that concept to the sale of cigarettes to minors, it is immediately obvious that it is the sellers who are the criminal wrongdoers. That teenagers (whether for reasons of psychological weakness, bravado, or sheer addiction to nicotine) "freely choose" to participate, is entirely irrelevant to this mode of social analysis and public policy.

APPLICATION OF PROTECTIVE LEGISLATION TO ILLEGAL SALES OF CIGARETTES TO MINORS

The lawsuit of *Kyte v. Phillip Morris, Incorporated* (Massachusetts Supreme Judicial Court #SJC-5165) is simply my application of that concept to a civil litigation setting. As the attorney for a public interest anti-smoking organization in Massachusetts ("GASP"), I have undertaken, in the setting of a "test case" brought by two minors who regularly purchased Marlboro cigarettes, to use the notion of "protective legislation" in a new way.

The illegal sales of cigarettes to my clients represent the Achilles Heel of the tobacco industry.

First, the manufacturers themselves must (at least publicly) agree that the State statutes making illegal sales of their product to minors are valid and worthy of enforcement. As far as I know, no official of any tobacco company has ever argued either that the laws should be repealed, or that they should remain unenforced. (Until the bringing of this suit, to attendant national publicity, of course, those laws were effectively never enforced. When did you ever see a policeman arrest a shopkeeper for selling a pack of cigarettes?) Thus, the tobacco companies are forced to officially accede in principle to their own ultimate destruction. Because almost all smokers begin when sales to them are illegal; and few who reach the age of reason and consent to embark on the hazardous course of smoking, universal enforcement of the State protective laws would be, overtime, the death knell of the industry.

In this regard, careful attention should be paid to the accompanying pleading from the *Kyte* case, which sets forth a rough estimate as to the magnitudes involved.

Second, in reality however, for precisely that reason, the cigarette manufacturers must see to it that the laws barring sales of cigarettes to minors remain a dead letter. Given the general problem of under-regulation by public officials (see Edward Greer, "Administrative Law and Chronic Underregulation in the Modern State," in J. Lobel [ed.], *A Less Than Perfect Union: Alternative Perspectives on the U.S. Constitution* (New York: Monthly Review Press, 1988), one simply cannot expect the government apparatus to do the job of stopping illegal sales to minors by itself.

Third, that situation prevailing, *private enforcement* of the protective legislation barring cigarette sales to minors provides the means to effectuate the objective. The *Kyte* lawsuit represents my effort to implement this strategy to attach and destroy the cigarette industry. In a handful of instances, as with asbestos, multiple private lawsuits for damages have cumulatively destroyed even large multinational corporations.

There is no reason not to attack this industry at its Achilles Heel: the unlawful sales of cigarettes to minors.

IMPLEMENTATION OF THIS STRATEGIC ATTACK ON THE ACHILLES HEEL IN THE *KYTE* CASE

To the best of my knowledge, no one has ever previously undertaken any litigation of this character and with this kind of structural reform objective.

The central legal problem presented by this lawsuit is that manufacturers are insulated from the direct illegal act of retail sale by two tiers of independent corporate intermediaries, namely, the distributors and the retailers. Because their official position is that such sales to minors are illegal and the law should be enforced, the manufacturers' main defense is that they have nothing to do with the illegal act and hence are not liable for it. (In the technical doctrine of private tort law, this defense is recognized as an absence of any *duty* to the harmed individual).

A second legal defense which I shall not address in this setting, is that even if there were otherwise a legal duty pursuant to State law on a manufacturer regarding illegal sales of cigarettes to minors, any potential civil liability in damages is *preempted* by the "Federal Cigarette Labeling and Advertising Act." If that were the case, no lawsuits such as the *Kyte* case would be possible. (For those interested in the legal doctrine of preemption in the area of personal injuries, my treatise, Greer & Freedman: *Toxic Tort Litigation* (Prentice-Hall, 1989 and Supplement 1990) provides a useful technical introduction). I will only say that this legal defense has proven to be a powerful one in other cigarette litigation, and more generally in various products liability and other settings. But for various reasons, it seems to me to be weak in the circumstances of affirmative State public health statutes, such as the laws barring sales of tobacco products to minors.

Turning back to the primary defense of an absence of any recognized legal duty, the *Kyte* case is attempting to obtain from the judiciary a recognition that in the contemporary economy, a giant multinational corporation should not be permitted to insulate itself from liability from its actions by inserting juridically "independent" intermediary corporations between itself and the unlawful act.

For the better part of a century, since the development of the modern corporation, the legal system has recognized that if a manufacturer puts a defective product on the market, it will be liable for the reasonably foreseeable harm, even if the product is sold by a remote retailer to a customer unknown to the manufacturer. The duty to warn of dangers and the duty to design and manufacture to avoid defects in this setting of remote sales are well established and indeed, constitute the very core of products liability law.

The *Kyte* case asserts that a similar duty exists where, (as is alleged to be the circumstances of this lawsuit) the manufacturer both knows that there is a massive pattern and practice of sales to minors, and earns hundreds of millions of dollars in annual profits precisely from this massive illegal pattern. (See accompanying pleading estimating such sales). In that factual situation, especially one in which the

manufacturer in effect targets a youth market, the *Kyte* case argues that a comparable duty lies on the manufacturer to bear the cost of any injuries resulting from this pattern of unlawful sales.

Under this legal theory, it would not be enough for the manufacturer to weep crocodile tears about illegal sales to minors to avoid being held liable. It would be in breach of its duty to the minor victims unless it had taken every reasonable measure to actively prevent such sales. At a minimum, it has been suggested that manufacturers would have to require "carding" for age by retailers as a requisite to its distributors providing the retailer with stock, and requiring its distributors to help it carry out this duty as a requisite to initially providing the distributor with stocks of the product.

It should be added that the approach of this case incorporates a view that the minor consumer is currently injured from being sold cigarettes even prior to developing major diseases. First, the addiction itself is a palpable injury, and second, initial adverse effects on the young person's health constitute the basis for monetary damages. And while for any given minor, such money damages may be moderate, in the ensemble for the millions of victims, the amounts would bankrupt even the largest tobacco company.

If this lawsuit, or other comparable ones, succeed in establishing the principles of law just outlined, it is my belief that an ultimately fatal blow will have been dealt to the industry. Certainly, many other tasks will be necessary.

For instance, appropriate legislative changes would be needed to facilitate the bringing of such suits by private attorneys where contingency fee returns do not economically justify the time in litigating these cases. In particular, amendments to State criminal laws are needed to provide expressly for a "private right of action" together with attorneys fees for prevailing plaintiffs. I think that such legislative initiatives will make the process I have been discussing feasible, regardless of whether the pioneering *Kyte* case wins.

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

SUPERIOR COURT
C.A. NO. 87-1816

THERESA KYTE, et al, Plaintiffs, v. PHILIP MORRIS INCORPORATED, et al, Defendants	PLAINTIFFS ESTIMATE OF UNLAWFUL CIGARETTE SALES TO MINORS

As of this date, defendants have not cooperated in providing discovery as to the dollar amounts of sales of cigarettes, in particular Marlboro cigarettes, to minors in this Commonwealth. Until such time as this discovery is provided, the plaintiffs perforce must rely upon published data by government agencies and in the trade press. This pleading sets forth the factual basis for the estimates provided to this Court at Par.2 of the accompanying "Plaintiffs Rule 37 Motion to Require Defendant Store 24 to Provide Cigarette Sales Data," for the limited purpose of enabling this Court to assess the relevancy of the sought discovery.

A. Store 24, Inc.

At his deposition, Robert Gordon, President and majority shareholder of Store 24, Inc., testified that annual sales at his sundry retail outlets approximated one million dollars

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($1,000,000.00). Approximately one-sixth of those sales were of cigarettes. (Deposition, 45-49.) Thus, a typical Store 24 sells roughly three thousand dollars ($3,000.00) worth of cigarettes weekly. At $1.50 per pack, approximately two thousand packs of cigarettes are sold at each Store 24 outlet weekly at each Store 24.

Since about 5% of smokers are minors,[1] this would mean that -- assuming that Store 24 customers are statistically representative of the general population -- that about 100 packs are sold to minors weekly. But since part of these sales are by cartons, a conservative estimate is therefore that between 50 and 100 teenagers are sold cigarettes weekly.

B. Philip Morris, Inc.

Marlboros constitute 23.9% of all cigarette sales,[2] which are concentrated among youth. About 56% of minors who smoke cigarettes choose Marlboros.[3]

Since about five percent of all smokers are minors,[4] this means that approximately 12% (or one-eighth) of all

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[1] Advertising of Tobacco Products: Hearings before the Subcommittee on Health and the Environment of the House of Representatives Committee on Energy and Commerce, 99th Cong., 2d Sess., 510 (1986).

[2] 115 Tobacco Reporter 37 (January, 1988).

[3] Hearings, supra, 169.

[4] Id., 510.

Marlboros are illegally sold to minors.

And "Marlboros last year netted a nice round $2 billion in operating profits,"[5] so an eighth of its profits -- or a quarter billion dollars ($250,000,000.00) -- comes from illegal Marlboros sold to teenagers.

DATED: February 27, 1988

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[5] Forbes (February 9, 1987), 108.

STATEMENT OF

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON FINANCE

U.S. SENATE

MAY 24, 1990

EMBARGOED

For Release Only Upon Delivery

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify at today's hearing. I congratulate you for your efforts to focus attention on the issue of tobacco and health. Given the tremendous toll that tobacco addiction wreaks on our nation's health, and especially on the people served by programs under your jurisdiction, it is urgent that we work vigorously together to develop strategies to curtail use of this addicting substance. This hearing is especially timely because May 31st is "World No-Tobacco Day." This event, which is sponsored by the World Health Organization, is much like the Great American Smoke-out. The theme of World No-Tobacco Day this year is Smoking and Children.

Today I will summarize the scope and nature of the problem of tobacco addiction in the United States, particularly as it affects our nation's children and youth. I also want to discuss some of the steps my Department is taking to reduce the use of tobacco.

The Health Consequences of Smoking

We have made tremendous progress toward our ultimate goal of a smoke-free society since the first Surgeon General's report on smoking and health in 1964. A quarter century ago, 40 percent of

adults--and more than half of all men--smoked cigarettes. Today fewer than 30 percent of adults smoke, and almost half of all living Americans who ever smoked have quit. Per capita cigarette consumption has fallen each year since 1973.

Nonetheless, cigarette smoking remains the single, most important preventable cause of death in our society. Smoking is directly responsible for about 390,000 deaths each year in the United States; thus, we can fairly blame smoking for more than one of every six deaths in our country. It is astonishing to realize that the number of Americans who die each year from diseases caused by smoking exceeds the number of Americans who died in all of World War II, and this toll, unfortunately, is repeated year after year after year.

I am particularly concerned about smoking among pregnant women, and among our children and teen-agers. Women took up smoking in large numbers in the 1940s and 1950s. Since that time, the rate of smoking has declined much more slowly among women than among men. Cigarette companies have aggressively targeted women since 1928, when women were asked to "Reach for a Lucky Instead of a Sweet." A more contemporary advertising campaign associates smoking with women's liberation--"You've Come a Long Way, Baby."

However, these ads fail to point out that smoking is an equal

opportunity killer. Lung cancer has overtaken breast cancer as the number one cause of cancer death among women, and lung cancer death rates among women continue to increase at an unrelenting pace. Other smoking-related diseases, such as heart disease, and emphysema, also are exacting a terrible toll on women in this country. For example, a recent article published in the New England Journal of Medicine showed that women who smoke are more than three times as likely to have a heart attack as women who have never smoked. This study and hundreds of others have demonstrated that women who smoke like men are going to die like men who smoke. Smoking is one area where women are unfortunately outdoing men in one respect; at present, young women are more likely to smoke than young men.

Women who are addicted to tobacco are obviously affecting their own health, and that is unfortunate enough. But women who smoke during pregnancy are undeniably affecting their own babies. Women who smoke during pregnancy are more likely to have miscarriages, and they are more likely to have dangerously small babies, or babies who die during their infancy. To put it in very plain terms, being born too small is a hazard to your health, and too many of our babies are suffering this hazard as the result of women smoking during pregnancy. The danger of smoking during pregnancy is real -- smoking doubles the risk that a baby will die -- and it is pervasive -- there are around 900,000 infants born each year to smoking mothers. We know that

smoking increases a woman's chances of having an underweight baby. Anyone who has held an underweight baby in their arms, as I have, realizes what a tragedy it is to have a child begin its life way behind the "starting line". It is all the more tragic, when smoking is the cause, because smoking is avoidable.

These tragedies have a financial and budgetary impact as well. Neonatal intensive care for low birth-weight babies costs about $3 billion a year. We estimate that about one-fourth of all low birth-weight babies are attributable to smoking during pregnancy. Thus, elimination of all smoking by pregnant women could save up to $750 million nationally, and the savings to the Medicaid program are estimated to be between $150-200 million.

With these kinds of statistics, it is clear that elimination of smoking among child-bearing women would greatly reduce infant mortality and many other health problems and their associated costs. My Department conducts a number of programs which are trying to develop educational methods that can be used to reduce smoking among pregnant women. For example, through the "Smoking Cessation in Pregnancy" (SCIP) project, the Centers for Disease Control is providing assistance to states to develop and integrate smoking cessation information into public prenatal services. If the development of these educational methods is successful, then they can be applied more broadly.

Smoking among young people is a special concern of mine that I want to highlight today. Here's an area where we have had some good news. Smoking among high school seniors actually declined between 1976 and 1980 from 29 percent to 21 percent, but has leveled off since 1980. The really disheartening news is that some one million teens start smoking each year; this amounts to about 3,000 each day, and many of these go on to become addicted for life. In fact, about 90 percent of adult smokers began their addiction as children or adolescents, so the conclusion is clear: these young smokers account for almost all of our future problems. We know that the younger a person is when he or she starts to smoke, the more likely he is to become a long-term smoker and to develop smoking-related diseases. Preventing youngsters from taking up smoking is far more cost-effective than treating addiction later in life, and far less expensive than treating the resulting diseases.

As long as a significant proportion of teens view smoking as a desirable, adult pleasure, and become addicted before they can make a mature judgment, we will never succeed in achieving a smoke-free society. It is all too apparent that we, as parents, as educators, as health officials, and legislators, still do not take the problem of smoking among our children and adolescents as seriously as we should. We allow, for example, a constant barrage of cigarette advertising that portrays smoking as safe, sexy, and sophisticated, themes which appeal strongly to

impressionable adolescents. And we have found it convenient to look the other way as cigarettes are openly sold to our nation's youth.

As with so many other health issues, tobacco addiction should be attacked with prevention measures, and this means that we should mount a vigorous effort to discourage our children and youth from ever starting to smoke. With this in mind, I want to present to you today a new initiative, one which I believe has the potential to make a great contribution towards smoking reduction among youth.

Improved Enforcement of State Laws Against Smoking by Minors

In March I asked the Office of the Inspector General (OIG) of HHS to assess the enforcement of state laws prohibiting the sale of cigarettes to minors. I also asked my staff to explore techniques which states could adopt to improve the enforcement of these laws.

I am releasing the OIG report today. I would like to summarize it and introduce a copy of the report into the record. Its findings confirm both the findings of other studies and what we already suspected from every day observation. The findings boil down to this simple and unacceptable fact: our children can

easily buy cigarettes virtually anytime they want to in violation of the law. Clearly, something has to change!

The OIG collected information in three ways. First, law enforcement and public health officials were contacted in every state to obtain data on enforcement activity and the views of these officials regarding enforcement of these laws. Second, the OIG identified and obtained information on unique, aggressive, and effective state or local enforcement efforts. Third, the OIG interviewed 1200 law enforcement officials, public health officials, educators, youth, parents, and vendors in 18 states and over 300 communities to assess their knowledge of enforcement.

Let me now provide the highlights of this report:

o Forty-four states and the District of Columbia have laws which make it an offense for retailers to sell cigarettes to minors. However, these laws are being blatantly ignored.

o Of the 44 states with such laws, only five could even tell our investigators how many violations had been identified either at the state or municipal level. These five states found a total of 32 violations in 1989, and the remaining states simply didn't know. Thus, nationally we can document 32 violations of the sales laws, while we know

that almost one billion packs of cigarettes are illegally sold to our youngsters each year. This is truly a national disgrace.

o Two-thirds of the state public health officials reported that there was virtually no enforcement of their state law, and most of the rest said enforcement was minimal.

o Because most youth access laws are criminal statutes, only the police can enforce them. Law enforcement officials said that other enforcement priorities and a reluctance to take such cases into crowded court systems dampened their enthusiasm to enforce these laws.

o Over 80 percent of both students and adults interviewed by the OIG reported that it is easy for youth to buy cigarettes. Over 60 percent of vendors agreed.

As you can see, the overall enforcement record is abysmal. The OIG, however, did find tiny pockets of active enforcement, mostly local communities with strong and enforceable laws.

o The OIG identified eleven jurisdictions where officials have made serious attempts to end the sale of cigarettes to minors. These communities are: the state of Florida; Leominster and Brookline, Massachusetts; Woodridge,

Illinois; Allentown, Pennsylvania; Minneapolis and White Bear County, Minnesota; Layton, Utah; King County (Seattle), Washington; Marquette County, Michigan; and Solano County, California.

o The jurisdictions that the OIG identified are successfully enforcing their laws and have offered recommendations for even better performance. The enforcement tools which seem effective in these communities include licensing of tobacco vendors and revocation of licenses for violations, civil rather than criminal penalties for violators, use of "stings" to identify illegal sales, posting of signs at points of sale, and bans or restrictions on vending machines.

o Above all, these communities have found that leadership by government officials accompanied by local support and commitment are vital.

In sum, where state and local officials take their responsibilities seriously, and devise enforcement tools which are workable and effective, these laws can be successfully enforced. The job can be done! In just these few communities, it is likely that tens of thousands of youth will avoid addiction and extend their healthy lives. What other public health initiative can promise such results at such low cost?

I also asked my staff to use the experience of successful--and not so successful--enforcement efforts to develop a model law which states could adopt. Today, I am releasing the "Model Sale of Tobacco Products to Minors Control Act," and I recommend that every state in the union consider legislation along these lines. I hope that the Nation's governors, all of whom are certainly interested in practical preventive health measures, will get behind legislation to attach this critical problem. We will be working with the leadership of the National Governors Association and other groups to assure that the model bill is considered in each and every state.

I would like to summarize the proposed legislation and introduce a copy of it into the record. The proposed model law has several key features, which would do the following:

o Create a licensing system, similar to that used to control the sale of alcoholic beverages; thus, a store could sell tobacco to adults only if it avoids selling to minors. Signs stating that sales to minors are illegal would be required at all points of sale.

o Set forth a graduated schedule of penalties--monetary fines and license suspensions--for illegal sales so that store owners and employees face punishment proportional to

their violation of the law. Penalties are fixed and credible. Those who comply need pay only an annual license fee.

o Provide separate penalties for failure to post a sign, and higher penalties for sales without a license.

o Place primary responsibility for investigation and enforcement in a designated state agency, such as the State Health Department, but allow local law enforcement and public health officials to investigate compliance and present evidence to the state agency or file complaints in local courts.

o Rely primarily on civil penalties to avoid the time delays and costs of the court system, but allow use of local courts to assess fines, similar to traffic enforcement. This provides flexibility to both state and local authorities to target enforcement resources.

o Ban the use of vending machines to dispense cigarettes; this provision reflects the difficulty of preventing illegal sales from these machines. You can't buy beer from a vending machine, why should you be able to purchase cigarettes there? In recognition of the economic impact of

such a ban on vending machine owners, states may wish to consider a phased approach leading to a complete ban.

o Contain a number of features to minimize burdens on retail outlets: require identification only for those who are not clearly above the age set by the state, allow a driver's license as proof of age, set a nominal penalty for the first violation, disregard one accidental violation if effective controls are in place, have the state provide required signs, and set license fees lower for outlets with small sales volume.

I would add that our emphasis on civil money penalties in this model legislation reflects the success that my Department has had using this new tool, that was developed legislatively by the Finance Committee. The use of civil penalties has been particularly successful in addressing Medicare fraud.

In summary, the model law attempts to create workable procedures which will provide retail outlets the incentive and tools to refuse to sell tobacco to minors, as already required by law in 44 states. Stores which comply will have no burden other than a licensing fee and, in some cases, replacement of vending machine by over-the-counter sales. Compliance by responsible stores, which would quickly become the great majority, will enable state and local authorities to concentrate enforcement efforts on a

small number of recalcitrant outlets. The few stores which are unable or unwilling to prevent tobacco sales to minors may elect to stop carrying tobacco products, or will lose the license to sell them. Adult smokers would be unaffected by the proposed law.

Ultimately, the effectiveness of state laws depends on the willingness of concerned citizens to report violations to authorities who are responsible for investigations and enforcement. We are sure that enough citizens are concerned; the model law should help state legislatures develop an effective and efficient system to handle their complaints. However, we feel that merely putting an effective enforcement mechanism in place is the single most important reform. The better the mechanism, the less likely it will have to be used.

I would like to add that if some states are unable to put this proposal into place then cities and counties can certainly do so. The OIG study clearly showed that local jurisdictions can have a noticeable impact on cigarette sales to minors if they choose.

Regardless of the level, I urge the adoption of legislation based on this model bill. No state or city could take a more effective health-enhancing action for its citizens than enactment of a set of well-designed enforcement tools aimed at eliminating the sale of cigarettes to minors. Businesses, which are struggling with

the costs of providing employee health benefits, should recognize the long-term value of this bill, as it should diminish the number of people who get hooked on smoking while young -- only to become disease victims later.

Mr. Chairman, this proposal represents only one of the initiatives we are taking; you are well aware of my abiding concern for the impact smoking is having on minorities. I look forward to working with you and other members of Congress to promote a tobacco free lifestyle. Elimination of this addictive substance will do more to enhance the length and quality of life in the United States than any other step we could take. Unlike many of the issues which this Committee examines each year, moreover, smoking reduction can be achieved at very low cost to Federal or state budgets. Indeed, smoking reduction creates positive fiscal effects on employment and income tax revenues, and on both public and private retirement funds and medical insurance, due to prolongation of working years and reduced illness during those years.

I would be happy to answer any questions that you or other members of the Committee might have.

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YOUTH ACCESS TO CIGARETTES

OFFICE OF INSPECTOR GENERAL

OFFICE OF EVALUATION AND INSPECTIONS

MAY 1990

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent waste, fraud and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,400 staff strategically located around the country.

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This report is produced by the Office of Evaluation and Inspections (OEI), one of the three major offices within the OIG. The other two are the Office of Audit Services and the Office of Investigation. Inspections are conducted in accordance with professional standards developed by OEI. These inspections are typically short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud or abuse.

This study was conducted to assess the enforcement of State laws prohibiting the sale of cigarettes to minors.

This report was prepared under the direction of Thomas F. Tully, Regional Inspector General of Region II, Office of Evaluation and Inspections. Participating in this project were the following people:

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YOUTH ACCESS TO CIGARETTES

Richard P. Kusserow
INSPECTOR GENERAL

OEI-02-90-02310

MAY 1990

EXECUTIVE SUMMARY

PURPOSE

To assess the enforcement of State laws prohibiting the sale of cigarettes to minors.

BACKGROUND

As part of his initiative on smoking, Secretary Sullivan asked the Office of Inspector General to survey States regarding their laws on the sale of cigarettes to minors. He wanted to know the extent to which the laws are enforced, the nature of enforcement activities and the most effective practices.

Research has documented that millions of youth smoke, despite the existence of laws in 44 States and the District of Columbia prohibiting the sale of cigarettes to minors. Yet, a Journal of the American Medical Association article estimates that more than 3 million American children under age 18 consume 947 million packs of cigarettes yearly.

METHODOLOGY

The study team interviewed State health and law enforcement agencies to document any enforcement activity; conducted in-depth studies of 11 specific active State and local enforcement efforts; and completed 1200 interviews in 18 States with students, parents, vendors and other adults to assess the public's knowledge and awareness of laws prohibiting the sale of cigarettes to minors.

FINDINGS

- Youth access laws are not being enforced.
- Children can easily buy cigarettes.
- Areas of active enforcement are few; they rely on local leadership.
- Active enforcement involves a variety of techniques, primarily administrative in nature.
  - Among the most common approaches are licensing, fines, stings, restrictions on vending machines, and warning signs.

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INTRODUCTION

PURPOSE

To assess the enforcement of State laws prohibiting the sale of cigarettes to minors.

BACKGROUND

As part of his initiative on smoking, Secretary Sullivan asked the Office of Inspector General to survey States regarding their laws on the sale of cigarettes to minors. He specifically wanted to know the extent to which the laws are enforced, the nature of enforcement activities and the most effective practices. Although the Surgeon General reports that most States have youth access laws, there is little information on their enforcement.

Research has documented that children smoke. Each day more than 3,000 children start smoking. A Journal of the American Medical Association article estimates that more than 3 million American children under age 18 consume 947 million packs of cigarettes yearly. Additionally, 75 percent of current adult smokers started smoking before their 18th birthday. The Annual High School Seniors Survey, conducted in 1987 by the University of Michigan, reports that approximately one out of every five high school seniors smoke daily, and that over half the seniors who smoked began smoking by the eighth grade.

According to a study by the Minnesota Tobacco-Free Youth Project, the earlier a child starts using tobacco, the more likely it is that he/she will be unable to quit. The same study found that more than one-half of high school seniors who smoke daily have tried to quit without success.

States have responded to the fact that children smoke by passing laws that prohibit the sale of cigarettes to minors. Currently, 44 States and the District of Columbia have such laws. The age at which children are no longer considered minors ranges from 15 to 19, with 18 being the most common. These are not new laws; most were enacted between 1890 and 1920 as a result of pressure from activists who were trying to prevent young boys from smoking. As recently as 1964, 48 States had laws prohibiting the sale of cigarettes to minors, but some were repealed because they were considered unenforceable. In at least 11 States vendors must post signs stating it is illegal to sell cigarettes to minors.

Penalties for violation of these laws vary greatly -- from a $2 fine in Washington D.C., to a maximum of a $3,000 fine and/or a year in jail in Minnesota. In most States the penalty is a fine and/or jail. Despite the fact that virtually all States license the sale or distribution of cigarettes, only four have license revocation as a penalty for selling to minors. Most States leave enforcement to local law enforcement officials. However, in Florida and New Hampshire, State taxation agencies have the responsibility; in Massachusetts, it is the State Department of Public Health.

Indications that enforcement may be weak came not only from the observable fact that teens are smoking, but also from a number of studies and from controlled purchases or "stings" that demonstrated children can and do buy cigarettes. Dozens of such local "stings" have been run by researchers, local reporters, police, and health departments to test youth access laws. Generally, minors were able to purchase cigarettes illegally about 80 percent of the time.

Additionally, in 1987, nearly 90 percent of a sample of Minnesota 10th graders who smoked regularly reported that it was *very easy* to obtain cigarettes despite a State law. In the 1987 "National Adolescent Student Health Survey" of 1100 students, 73 percent of the 8th and 10th graders said it was very easy to buy; 13 percent said its fairly easy. Also in 1987, 90 percent of a sample of New Jersey high school students who smoked said they could *always* or *nearly always* buy cigarettes.

METHODOLOGY

Data collection was performed in three stages. Initially, the study team interviewed each State health and law enforcement agency where access laws exist to document enforcement activity. Interviews were conducted with a person designated in each State as the tobacco contact person in response to a request from the Association of State and Territorial Health Officials. This tobacco contact person described his/her awareness of enforcement activities as well as perceived problems with enforcement. The law enforcement official contacted was the State-designated National Crime Information Center (NCIC) contact, who was asked to provide statistics on the enforcement of these State statutes.

In the second stage of the inspection the team studied specific State and local enforcement efforts. An extensive literature review and contact with State officials, experts and academics in the youth smoking field indicated 10 local areas and one State, Florida, where enforcement was actively occurring. Individual communities actively enforcing youth access laws are located in California, Illinois, Massachusetts, Michigan, Minnesota, New York, Pennsylvania, Utah and Washington. In-person and telephone interviews, using open-ended discussion guides, were utilized to study these special enforcement efforts.

In the third stage, OIG staff assessed the public's knowledge and awareness of laws prohibiting the sale of cigarettes to minors. A questionnaire was developed, and almost 1200 interviews in urban and suburban settings were completed during April. The interviews took place in over 300 communities in eighteen States: California, Connecticut, Colorado, Georgia, Illinois, Kansas, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, Texas, Vermont, Virginia, Washington and Wisconsin. The subjects interviewed included 295 vendors, 322 students and 561 other adults. These adults included 112 school officials, 95 law enforcement officials, 87 public health officials and 250 parents. The number of respondents varies by each question.

FINDINGS

Youth Access Laws Are Not Being Enforced, and Children Can Easily Buy Cigarettes.

State officials report that laws are not being enforced.

Two-thirds of State health department officials indicate that there is virtually no enforcement of their State law; another fifth say it is minimal.

Nearly half of the State health officials believe the law is not being enforced because it is not a priority. "People don't get excited about tobacco," explained one health official. The general sentiment is captured in another official's response that "people feel [that] there are more important issues that must be enforced." Other State health officials cite both a lack of funding and difficulty in enforcing the law as reasons for nonenforcement.

State-level police data also confirm the minimal level of enforcement. The majority of NCIC control agencies contacted could not provide actual numbers on violations and enforcement. Of the 44 States with laws prohibiting the sale of cigarettes to minors, only five could provide any statistical information on vendor violations:

STATE	1989 VENDOR VIOLATIONS
Alaska	8
Connecticut	0.
Florida	16
New York	8
Vermont	0

A notable area of statistical accomplishment is Utah which in 1989 issued 4476 violations to minors for purchasing and/or possessing tobacco.

Law enforcement officials in the remaining States report that municipalities are either not required to report such minor offenses, or that all such offenses are lumped together in a miscellaneous category and cannot be accessed separately.

Discussions with local law enforcement officials further confirm the impression that little is being done. More than three-quarters interviewed from 78 communities around the country do not think youth access laws are being enforced in their communities. In fact, 76 of 89 (85%) report that they do not know of anyone ever being caught breaking this law.

Local public health officials agree. More than two-thirds interviewed believe the law is not being enforced in their local area; 64 of 73 respondents (88%) do not know of anyone ever being caught under this law.

Community respondents also note lack of enforcement.

More than three-quarters of respondents in the community also say youth access laws are not being enforced. This includes 246 of 320 student respondents (77%) and 429 of 559 adults (77%) including law enforcement officials. Half of the vendors surveyed agree.

Respondents in the community also do not know anyone who has ever been caught selling cigarettes to minors; 206 of 255 student respondents (81%) and 421 of 488 adult respondents (86%) do not know anyone who has ever been caught. The majority of vendors, 227 of 268 (85%), are likewise unaware of anyone ever being caught.

Respondents also say children can easily buy cigarettes in their community. The majority of adult and student respondents, 477 of 560 adults (84%) and 269 of 319 students (84%), consider it easy. Of 159 children who say they have smoked, 139 (87%) claim that it is easy to buy cigarettes. About two-thirds of the vendors agree.

Despite easy access and lack of enforcement, most respondents are, nevertheless, aware of the youth access law in their State. Three-quarters of students know of these laws. Similarly, 479 of 552 responding adults (86%), including 90 of 94 law enforcement officials (96%), are aware of them. Most store clerks, managers and owners, 266 of 292 (91%), know it is illegal to sell cigarettes to minors. When asked how they became aware of these laws, vendors most often mentioned that it is common knowledge, while others report that their employer informed them.

Lack of enforcement is due to apathy.

Overall, both adults and vendors suggest apathy as the major reason why these laws are not being enforced. Of the 429 adult respondents who believe the law is not enforced, 97 (23%) believe that the law is not a priority with the police or limited resources for enforcement exist. Ninety-five (22%) say the law is not a community priority and no one really cares about it. Ninety-three (22%) blame vendors for not caring who they sell to and just wanting the profits from sales. Only 17 adult respondents (4%) blame a lack of awareness of the law.

Vendors generally agree with adult respondents. Of the 145 vendor respondents who believe the law is not enforced, 30 (21%) say that vendors in general do not care who they sell to and find it inconvenient to check identification. Thirty (21%) believe that the police are too busy to enforce the law and 28 (19%) suggest public apathy.

Other respondents in the community attribute nonenforcement to, as one respondent noted, "a lack of political pressure to have police or anyone else enforce it." Others believe that teens would get cigarettes anyway, especially from vending machines, and that the law is too difficult to enforce.

The majority of experts in the youth smoking field and officials in the communities taking local initiative believe these laws are a low police priority. "The police don't acknowledge it as a problem," one respondent explained. As one local official noted, "Local cops have more than they can handle. They don't have time for this law." One expert commented that "enforcement is not occurring because the community is not making a fuss about it." Others cite a lack of leadership and the absence of an identifiable person or agency responsible for enforcement.

The majority of the law enforcement officials confirm that it is not a priority and say they have more important issues to address. As one officer notes, "The law is not important enough to have officers using their time to enforce it." Local law enforcement agencies also mention reluctance to take these cases into the congested court systems, noting that prosecution of criminal laws is not only time consuming but costly.

Areas of Active Enforcement Are Few; They Rely on Local Leadership.

Local leadership exists in nearly all active enforcement areas.

Eleven active enforcement initiatives were identified and contacted; all but one (Florida) were local initiatives supported by the community. These areas include:

Solano County, CA	Woodridge, IL
Brookline, MA	Leominster, MA
Marquette County, MI	Minneapolis, MN
White Bear Lake, MN	Allentown, PA
Layton, UT	King County, WA

In eight of these areas, local laws have been established and are being enforced, while in the remaining three the State law is being enforced.

In some States, these active communities have served as examples for other municipalities which have now also adopted similar enforcement policies. There may be more than one active town in each area; however, interviews were held only with those who first became active.

Generally, these enforcement initiatives have resulted from community concern and local leadership. In Woodridge, a local junior high school principal became concerned when a young student was seen purchasing cigarettes in a nearby store, and asked the youth officer from the local police department if it was illegal. After some research, the officer discovered it was, in fact, illegal. The officer then helped write a town ordinance prohibiting sale to minors and possession by minors. In the last year, three vendors' licenses have been suspended and over 30 minors have been ticketed. Many surrounding towns followed his lead and adopted similar local ordinances.

In Massachusetts, in response to an apparent lack of enforcement of the youth access law, the State Health Department asked local health departments to take on the responsibility. So far, two have accepted and are issuing tickets to violators. Both towns have adopted the State law as a local public health law, thus allowing enforcement by local health inspectors.

Information obtained at a smoking conference showing that nine percent of seventh graders smoke motivated the Allentown Health Department to look into enforcement of the State's law. In its first test of the law, it found that all 15 of its 15 test stores sold cigarettes to minors.

In Solano County California, the Cancer Control Program, concerned about the public health effect of teens smoking, encouraged three local police departments to enforce the State's law. These efforts resulted in 31 arrests.

Active Enforcement Involves a Variety of Techniques, Primarily Administrative in Nature.

Among the most commonly used techniques are licensing, fines, stings, restrictions on vending machines, and warning signs.

Licensing appears to be an effective tool in enforcing youth access laws.

Of the eleven active programs contacted, eight provide for revocation or suspension of the vendor's license following a prescribed number of violations. While all States license the production, distribution or sale of tobacco, only 31 license vendors; the remaining States license the wholesaler or the distributor. The source of these licenses varies; some are issued locally and others are issued by the State. Suspending a vendor's right to sell cigarettes for a period of time has greater impact than a fine, according to active enforcers. Since sales can account for hundreds of dollars of a store's daily intake, a minor monetary fine, in contrast, is relatively painless to pay. Also, a vendor who is forced to turn customers away may lose customers. Officials in these communities agree that a license revocation penalty causes vendors to obey the law. They point to the virtually self-enforcing alcohol laws as models.

Three types of license revocation were identified in the active communities. In Florida, the law prohibiting the sale of tobacco to minors is enforced by the Division of Alcoholic Beverages and Tobacco. Vendors who violate cigarette access laws can and do have their license to sell alcohol suspended. This occurred 16 times last year. In Brookline and Leominster, where the law is enforced by the local health department, vendors lose their food licenses. The first license was suspended recently. In the remaining sites, tobacco licenses issued locally to vendors are revoked when misused. In all three cases, suspensions are for a period of days for the first offense and longer for each added offense. One active enforcer stressed the importance of making these punishments reasonable. "If you make it too severe, you'll lose that crucial community support."

License fees vary greatly and can be used in many ways. Fees charged for these vendor licenses range from $5 for 3 years in Marquette County, MI to $210 for 3 years in King County, WA. In some areas (King County and Florida) fees are earmarked to pay for enforcement, while in others (Brookline) they fund tobacco and health education programs.

Civil fines work better than criminal penalties.

While criminal offenses must work their way through the criminal justice system, civil offenses are generally handled administratively. Seen as a viable alternative in the enforcement of youth access laws, they are used in six of the eleven active communities. Civil penalties expedite enforcement through the use of non-traditional enforcement officials (i.e., health inspectors, licensing inspectors, etc.), and avoid needlessly clogging the criminal justice system. In Minnesota, the penalty for selling to a minor is a gross misdemeanor, which if enforced, could mean jail for the clerks who sell. However, when three clerks in Ramsey were arrested for selling to minors, there was a public outcry for more lenient penalties. Minneapolis thus chose to punish violators civilly, going after the owner's license rather than the clerk.

In Florida, the access laws are criminal and violators must appear in court. Criminal court judges, however, feel strongly that these violators should not be burdened with a criminal record for such a common offense. The judges issue fines, but the violators are not adjudicated as guilty and, therefore, avoid criminal records. In some California criminal courts, judges have suspended sentences and have only issued fines. They also believe that criminal penalties do not fit this crime.

In Leominster and Brookline, sanitarians and public health officials issue tickets on which the fines are outlined. Cases are handled entirely by the health department; the police are not involved.

Overall, civil penalties are well received by active communities. When asked why other State youth access laws are generally not enforced, a majority of active community respondents believe it is because it is not a police priority; some blame public apathy. They feel that people, while not wanting children to purchase cigarettes, believe that police should be concentrating on more important issues, like illegal drugs and rape.

Police involved in actively enforcing these laws believe that the laws should be civil as opposed to criminal and would be more appropriately enforced by health departments and licensing officials. One of the more successful police enforcers stated, "The police department should not enforce this law. Citizens would argue there's not enough manpower. The health department is a more appropriate arm because it is not an offensive crime. It is a health issue - an administrative issue."

Stings are most often recommended as an enforcement technique by active communities.

A sting is conducted under the supervision of an enforcing agency which attempts to have a teenager purchase cigarettes from a vendor. All but two of the active localities use stings. In some cases, teenagers are paid by the agency running the sting and are considered special agents. Recruited from schools, advocacy programs, or police cadet programs, they are chosen because they look young and are warned not to lie about their age if asked, to avoid charges of entrapment. In some areas of Florida, the children are taken before a judge prior to the sting to assure that they look underage. In some communities, like Woodridge, a plainclothes officer enters the store before the child and pretends to be shopping so the purchase can be witnessed. Although the Woodridge law does not require that the officer witness the sale, police feel it adds to the validity of the charges. Woodridge estimates that quarterly stings of all 34 of its local tobacco vendors can be completed in just 4 hours by one officer. In addition to running quarterly stings, Woodridge also follows up on complaints from the community with additional stings.

Several active communities noted that stings by researchers and activists eventually led to community involvement. In California, the Solano County Cancer Prevention Program conducted the initial stings to see if there was a problem, not to catch violators. This led to stings by police with violators being punished. Likewise, in Woodridge, DePaul University researchers performed several stings to alert the town council to the existence of the problem, which led to the creation of the local ordinance.

When asked for suggestions as to how youth access laws could be enforced, the use of stings was the answer given repeatedly, with one respondent stating that, "Stings are vital to enforcement." Additionally, active enforcers generally believe that stings should be done regularly as opposed to being done only in response to a complaint. Another active enforcer said, "Stings are the only way to enforce. Complaints are not enough; no one complains. There is no alternative to stings."

The accessibility of vending machines is addressed when designing successful youth access laws.

Vending machines are estimated by a National Automatic Merchandising Association study to account for 16 percent of illegal cigarette sales to minors, and the younger children are, the more likely they are to purchase from a machine. Enforcement experts agree that effective youth access legislation should deal with vending machines. Currently, 51 percent of State health department officials report that they have no policy concerning vending machines, and another 33 percent say they merely require a warning sign to be posted on the machine. In contrast, seven of the eleven active communities deal with vending machines with total bans, locking devices or limited placement requirements.

Limited placement allows for vending machines in places that do not normally allow children anyway (i.e., bars, offices or factories). Currently, only 6 percent of State health departments interviewed report that their youth access laws limit the placement of vending machines, but half suggest limiting placement.

Locking devices require the installation of a relatively inexpensive device that inactivates the machine until a clerk triggers the power, thus allowing the clerk to check the age of the purchaser. Utah experimented with locking devices recently with limited success. Reportedly, clerks would simply activate the machine without checking the age of the purchaser. Since locking devices require employee participation, they are often not as effective in busy places, such as bars or restaurants, where employees are more likely to simply activate the machine.

Sixteen municipalities in Minnesota recently banned cigarette vending machines entirely. These bans have generally been well received and are expected to lead to stricter enforcement of over-the-counter sales. The remaining 42 percent of State health department officials say that total bans are the only way to prevent teens from using vending machines.

Warning signs remind both clerks and customers that sale to minors is illegal.

Currently, seven of the eleven active communities require vendors to post signs at the point of sale stating that it is illegal to sell to minors. Similarly, 55 percent of State health departments say vendors in their States are required to post warning signs. In Massachusetts, vendors must place these signs in such a way that they face the clerk as a constant reminder. In Utah, innovative designs and neon colors have been used to make signs distributed by local health departments more noticeable. In addition to signs, Woodridge clerks wear buttons reminding customers of the new ordinance. While enforcement experts stress that signs alone are not enough to stop illegal sales, they are a constant reminder to both children and employees.

Experts believe that making tobacco laws similar to alcohol laws would be an effective enforcement mechanism.

Enforcement in Florida, conducted by the Division of Alcoholic Beverages and Tobacco, is the same for alcohol and tobacco sales to minors, although ages differ (21 and 18, respectively). Three other States with similar alcohol/tobacco control agencies are not actively enforcing tobacco access laws, although they have the authority. At least two alcohol control agencies (ME, WA) report that their State legislatures are considering authorizing them to enforce existing tobacco access laws. Sixty percent of State health department respondents believe that the alcohol enforcement model would work for tobacco, and point to the license revocation provision in particular. Those who feel that the alcohol enforcement model would not work for cigarettes cite the extremely high number of tobacco vendors, which far exceeds the number of alcohol vendors.

Those proposing new youth access legislation are cautioned not to preempt any already existing local activity.

Officials in charge of active enforcement initiatives based on locally enacted ordinances caution that State laws should not preempt stronger local legislation. As a case in point, California recently passed a State law which precludes municipalities from enacting tobacco control laws.

Opinions vary as to whether or not to make it illegal for minors to possess cigarettes.

In five of the eleven sites contacted, it is illegal for a child to possess cigarettes. Enforcement experts believe this makes enforcement easier, serves as an additional deterrent and gives the vendor leverage when refusing to sell to minors. Penalties for youth violators range from 5 hours of community service to a $50 fine. In two areas enforcement is directed at the minor as opposed to the vendor: ticketing teens and suspending them from school and extra-curricular activities for possessing cigarettes is central to Utah's approach; White Bear Lake, MN brings them to the police station when caught in possession of cigarettes. California notes that caution must be used when performing stings in communities where possession or purchase is illegal. These minors must either be police agents or have special police permission.

Coalition on Smoking OR Health

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PUBLIC COMMENT OF

THE COALITION ON SMOKING OR HEALTH

AMERICAN LUNG ASSOCIATION
AMERICAN HEART ASSOCIATION
AMERICAN CANCER SOCIETY

FRAN DU MELLE, CHAIRPERSON

Before the Interagency Committee on Smoking and Health
National Advisory Committee
"Preventing the Sale of Tobacco to Minors"
May 31, 1990

American Heart Association

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Good afternoon. I am Fran Du Melle, Chairperson of the Coalition on Smoking OR Health and Director of Government Relations for the American Lung Association. The Coalition is made up of the three largest voluntary health organizations in this country: the American Heart Association, the American Cancer Society, and the American Lung Association. We appreciate the Committee's holding of this meeting concerning the need to prevent minors' access to tobacco products, and we are glad to welcome our nation's new Surgeon General, Dr. Antonia Novello, into the fray.

The easy access that our nation's children have to cigarettes and smokeless tobacco is a crisis of dramatic proportions, demanding a dramatic and effective response from the federal government, as well as from state and local governments. As the Inspector General of the Department of Health and Human Services reported recently, the laws in existence in 44 states and the District of Columbia prohibiting the purchase of tobacco products by minors are unenforced and, therefore, in the circumstances, useless. Tobacco products are easy for children to obtain because of the lack of regulations governing their sale and distribution, lax attitudes about enforcement, unrestricted free sampling, and the availability of tobacco products from vending machines. As a result, virtually all of those who smoke start before they are legally old enough to buy cigarettes.

The easy availability of tobacco products to children

seriously undermines government and private sector efforts to reduce consumption among this age group. Efforts to prevent children from smoking need to be buttressed by federal, state and local government initiatives to limit the sale of tobacco products to minors. We commend proposals that have been made encouraging state and local actions to combat this problem. However, while commendable, proposals for state and local action must be combined with federal action if we are to effectively combat what clearly is a national crisis. Cigarette smoking among young people requires implementation of a national law, not merely the placing of the entire responsibility on 50 different states to enact and enforce 50 different laws.

All of our nation's children need and deserve equal protection from this deadly and addictive product. Federal action should include a mandated national minimum age, placing the primary enforcement responsibility at the state level, but retaining federal authority to establish minimum standards for those jurisdictions which do not do so on their own. Federal action should also include a prohibition on all free sampling of tobacco products to prevent their distribution to children, as well as a prohibition on the sale of tobacco products except by license and by or under the direct supervision of an individual old enough to legally purchase these products in order to prevent the unrestricted, unsupervised sale of tobacco products in vending machines.

Moreover, we cannot expect to significantly reduce tobacco's toll on our nation if we seek only to prevent children's access to tobacco products. The federal government also needs to address the outrageous efforts of the tobacco industry to market their deadly products to our boys and girls. The tobacco industry spends $3.27 billion a year -- that's $9 million a day -- to entice children and adolescents to smoke. The result? At least three thousand minors starting to smoke every day, one thousand or more of whom will die from it.

As long as R.J. Reynolds' cartoon camel (see attachments) and Philip Morris' ever-present Marlboro cowboy are allowed to work their magic on our nation's youth -- promising success, glamor, sexual and athletic prowess, and wealth -- efforts to reduce tobacco use by youth will be frustrated at every turn.

The federal government must do away with the contradictory message sent to our children by eliminating or significantly restricting the image-based advertising used so ingeniously by the tobacco industry to lure our children into lifelong addiction and painful, early death. The federal government also must prohibit tobacco company promotions designed to attract our youth, such as Camel auto racing, Virginia Slims tennis, Marlboro soccer, Parliament rock 'n' roll compact disks, Carlton calculators, the Red Man chewing tobacco Greatest Cowboy Shootout, the Winston Sports Connection Trivia Challenge, the Newport skiing tour, and all manner of free videotapes, baseball

caps, young girls' hairbrushes, dance contests, t-shirts, etc.

We hope that the Surgeon General and the Interagency Committee on Smoking and Health will recommend strong action at all levels of government on these issues. Youth access and the image-based incentives for youths to smoke both must be eliminated.

Until the federal government acts to ensure that tobacco products are no longer readily available and tobacco industry efforts to attract young people are curtailed, efforts to reduce tobacco-related death and disease in our society will be severely hampered.

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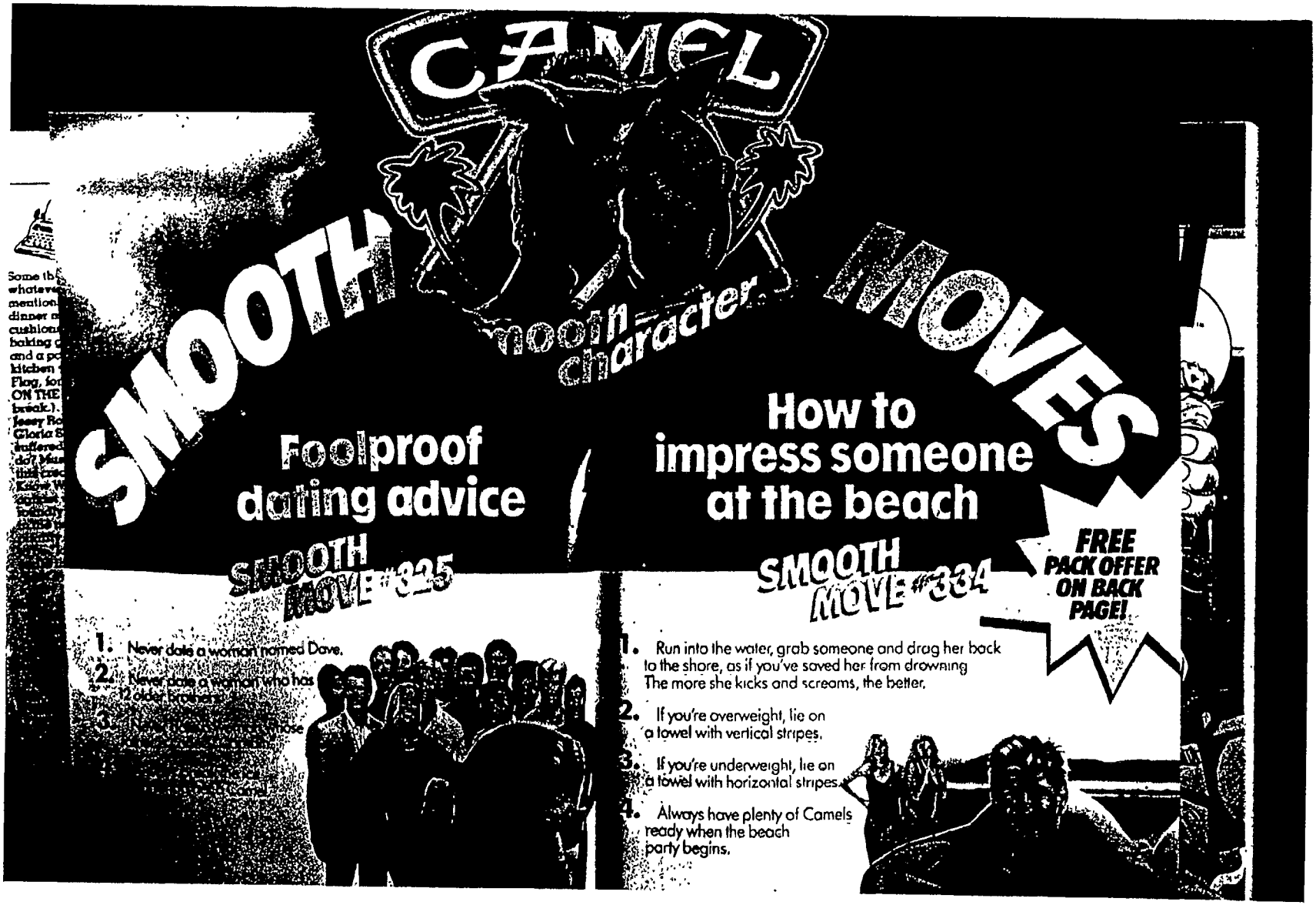
CAMEL ADVERTISEMENTS APPEARING

IN SPORT, ROLLING STONE, AND

NATIONAL LAMPOON

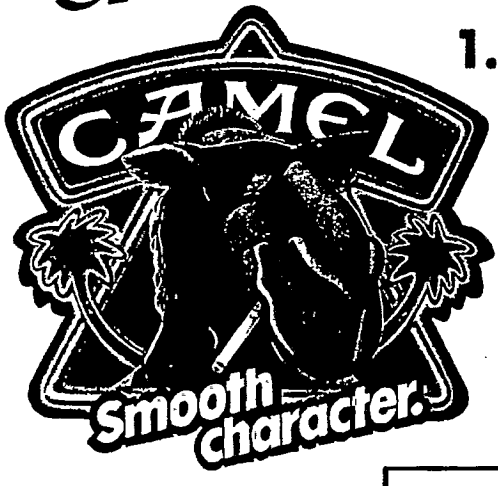


2026172500

2026172501

How to get a FREE pack even if you don't like to redeem coupons.

SMOOTH MOVE #437



1. Ask your best friend to redeem it.
2. Ask a kind-looking stranger to redeem it.
3. Ask a good-looking stranger to redeem it.
4. Offer each a Camel and start a warm, wonderful friendship.

SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.

LIGHTS: 9 mg. "tar", 0.7 mg nicotine, LIGHTS HARD PACK 10 mg. "tar", 0.7 mg nicotine, LIGHTS 100's: 12 mg "tar", 0.9 mg nicotine, FILTERS: 16 mg. "tar", 1.0 mg. nicotine; FILTERS HARD PACK 17 mg "tar", 1.1 mg. nicotine, FILTERS 100's: 18 mg "tar", 1.2 mg nicotine, REGULAR 21 mg "tar", 1.4 mg. nicotine, av. per cigarette by FTC method

90704 MANUFACTURERS COUPON EXPIRES 8/31/89

5 12300 10100 9

FREE Pack Of Camel!

When You Buy 1. Any Style.

RETAILER, YOU MUST FILL IN NORMAL RETAIL PRICE _____ (DO NOT INCLUDE SALES TAXES)!

90704

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WHEN ONLY A SMOOTH MOVE WILL DO...

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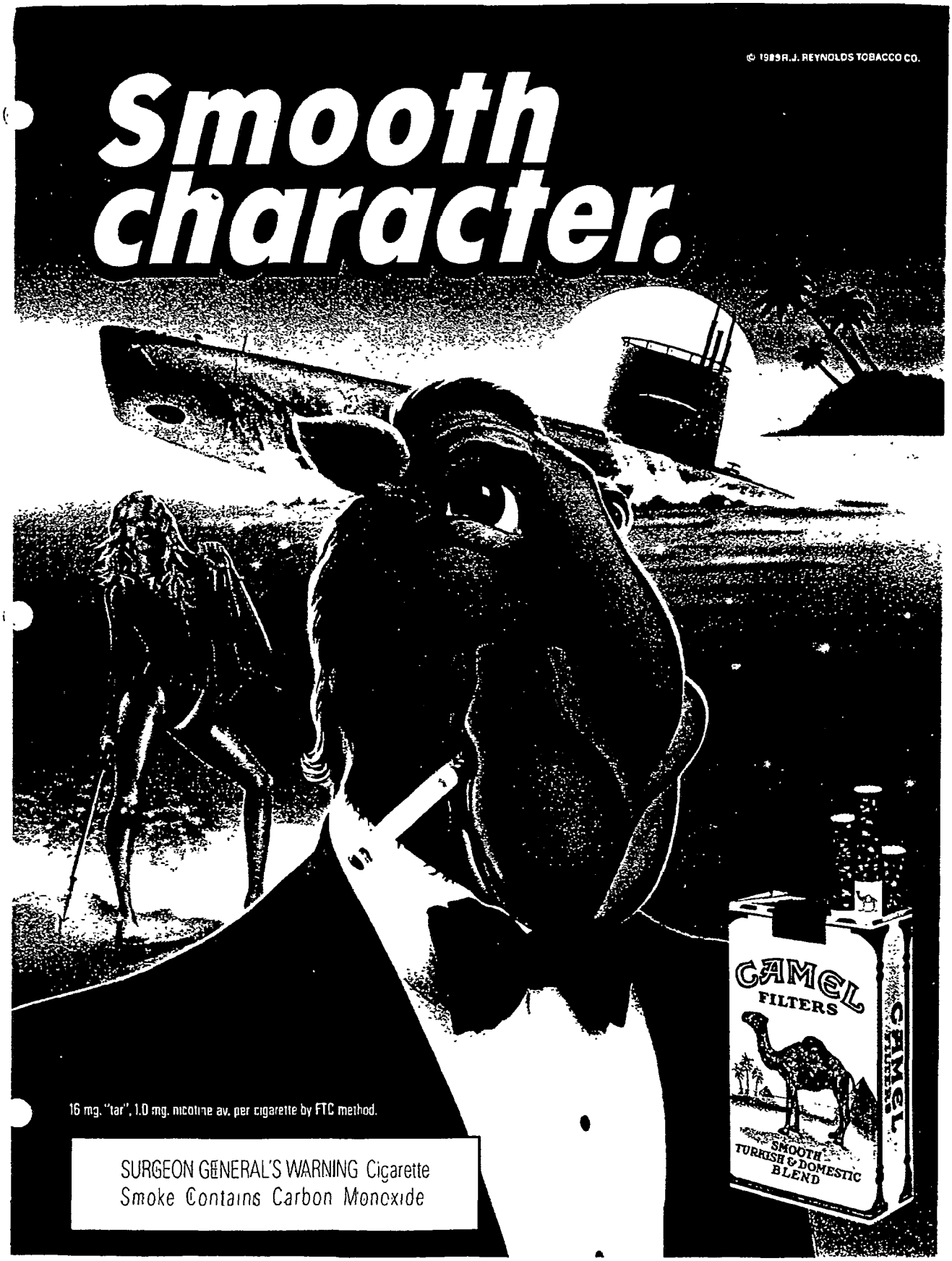
CAMEL ADVERTISEMENTS APPEARING IN MOVIES USA



Smooth character.

16 mg. tar, 1.0 mg. nicotine av. per cigarette by FTC method.

SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health.

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Coalition on Smoking OR Health

1607 New Hampshire Avenue, N.W., Washington, D.C. 20009
(202) 234-9375

Movies USA Magazine: Targeting Youth with Cigarette Advertising

Movies USA Magazine:

Movies USA premiered in March 1989. It is distributed monthly, without charge, by five of the largest movie theater chains in the United States: Cineplex Odeon, with 1,643 screens; General Cinema, with over 1,350 screens; Cinemark, with over 400 screens; Carmike Cinemas, with 669 screens; and Mann Theatres, with over 400 screens. Marketing materials distributed by the publisher of Movies USA explain that the magazine's target is "a captive audience of one million moviegoers" who are "youthful" and "image-conscious." The objective, the publisher continues, is to "t[ie] in promotions with the glamour and excitement of Hollywood and the movies." Actual readership is estimated at 3,000,000 monthly.

Advertisements appearing in Movies USA promote a number of products likely to appeal to high school girls and boys.

Advertisements in Movies USA for Camel Cigarettes:

Every issue of Movies USA contains advertisements for one or more of R.J. Reynolds' cigarette brands, Camel, Magna or Salem.

The Camel ads which have appeared in Movies USA, like those which have appeared in other popular magazines with substantial youth audiences (e.g., Rolling Stone, Sport, National Lampoon), portray a smiling cartoon dromedary smoking a Camel cigarette under the heading "Smooth Character." The ads portray the camel as a fighter-pilot, debonair gambler or "James Bond" type figure, always in the company of a voluptuous and often scantily clad young woman gazing admiringly at him. In the context of Movies USA, the connection between Camel cigarettes and sexual attractiveness, material wealth, fame and a daring lifestyle is made that much more explicit.

Moviegoer Age Demographics and Readership of Movies USA Magazine:

A high percentage of the readers of Movies USA are children and teenagers. Of those who read the magazine, moreover, the youngest readers pay the most attention to the magazine, according to a study conducted for the Motion Picture Association of America, Inc., Worldwide Market Research Group ("MPAA"), and a Movies USA reader survey released in October 1989.

According to the MPAA study, 12% of moviegoers in 1988 were age 12-15, and another 32% age 16-24. As explained in a September 18, 1989 Advertising Age article included in the Movies USA marketing kit, advertisers are lining up to show commercials at movie theaters in the United States because they are "full of captive, hard-to-reach young adults."

The results of the Movies USA reader survey illustrate the magazine's appeal to its youthful readers:

- The survey results establish that those under age 18 attend the movies more frequently than do those in other age groups. Of those under 18, 8.2% responded that they had attended movies 15 or more times in the last 90 days, while 5.2% of those 18-24 and 3.3% of those 25-34 did so.

- The results also showed that those under 18 spend considerably more time reading or looking into Movies USA than those in other age groups. Those under 18 offered a higher percentage (19.2%) of individuals who read or look into each issue of Movies USA between one and 1.5 hours than those 18-24 (15.3%) and 25-34 (10.2%). Fully 5.8% of those under 18 responded that they read or look into Movies USA four hours or more, in contrast with only 0.2% of those 18-24 and 0.3% of those 25-34.

- Of readers under 18, 38.5% said that they save the magazine after they finish reading it, substantially more than the 26.3% of those 18-24 and 16.1% of those 25-34 who do so.

- Of those under 18, 21.2% said they clip items of interest, while 15.1% and 12.8%, respectively, of those 18-24 and 25-34 said that they do so.

- Of all readers of the magazine under 18 years of age, fully 42.3% rated the magazine "excellent." Only 26.6% of those 18-24 and 23.2% of those 25-34 rated the publication as highly.

Attached are copies of advertisements for Camel cigarettes that have appeared in Movies USA and other publications.

NATIONAL AUTOMATIC MERCHANDISING ASSOCIATION

Serving the Vending / Foodservice management industry

To The Interagency Committee on Smoking and Health

STATEMENT OF THE NATIONAL AUTOMATIC MERCHANDISING ASSOCIATION

ON BEHALF OF THE VENDING INDUSTRY DESCRIBING ITS ROLE IN THE PREVENTION OF CHILDREN'S ACCESS TO TOBACCO PRODUCTS

By

Richard W. Funk
Chief Counsel

Hearing: May 31, 1990

HEADQUARTERS: 20 N. Wacker Drive, Chicago, IL 60606-3102 (312) 346-0370 FAX (312) 704-4140
EASTERN OFFICE: 11718 Bowman Green Drive, Reston, VA 22090-3501 (703) 435-1210 FAX (703) 435-6389
WESTERN OFFICE: 16030 Ventura Boulevard, Encino, CA 91436-2745 (818) 783-8363 FAX (818) 783-0232

Madam Chairman Novello and distinguished members of the Interagency Committee on Smoking and Health, my name is Richard W. Funk and I am Chief Counsel of the National Automatic Merchandising Association. The National Automatic Merchandising Association is the national trade association of the merchandise vending business. 1200 companies which belong to our association operate merchandise vending machines and of these, more than 850 sell cigarettes through vending machines. They strongly support efforts to prevent children's and teens' access to tobacco products.

Vending machines are the least likely source of cigarettes for smokers ages 13 through 17. A variety of studies and other data support this finding.

Retail cigarette merchandising establishes the following patterns:

- The sale of cigarettes through vending machines represents 3.5% of the total market

- There are approximately 375,000 cigarette vending machines on location nationally, 80 per cent of which are located where persons under the age of 18 are not allowed access or rarely frequent

- 28 per cent of smokers aged 13 through 17 do not purchase cigarettes, but get them from friends and family

- Almost half (45%) of teenage smokers are permitted by their parents to purchase cigarettes.

A study underwritten by us conducted by the independent market research firm Response Research, Inc. headquartered at Chicago, Illinois in June and July, 1989 analyzing teenage smoking and purchasing behavior (persons 13 through 17 years of age) showed that frequent purchasers of cigarettes rely much more on over-the-counter sources than on vending machines. Almost two-thirds of the frequent purchasers (64%) buy over-the-counter often whereas only one in eleven (9%) buys often from vending machines. Those who purchase over-the-counter often or occasionally cited four locations as the ones they go to most frequently: convenience stores (43%), gas stations (29%), grocery stores (11%) and drug stores (6%). A summary of this report is attached to this statement.

A nation-wide cigarette vending machine placement study was conducted in March, 1986 among the then 1,000 or so N A M A member companies who operated cigarette vending machines. 590 replied to the questionnaire asking where their cigarette vending machines were located. The survey covered virtually every state. The study showed that about 8 out of 10 cigarette vending machines are located where teenagers are not allowed or rarely frequent.

Bars, Cocktail Lounges	31%	OTHER LOCATIONS	
Industrial Plants	27%	Restaurants	13%
Offices	12%	Service Stations, Government-Military, Retail Stores, Transportation Terminals, Rec.-Bowling Centers, Misc.	9.5%
Hotels/Motels	4%		
Universities/Colleges	3.5%		
TOTAL	77.5%		22.5%

These figures are confirmed by similar more recent individual state studies. For example, a 1988 survey in the state of Michigan totaling 4,048 machines, showed

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that 95.6% of these machines are located in places where minors are not allowed or are well supervised. This survey included more than half of all licensed cigarette machines in Michigan. In 1988 only 3,494 new cigarette vending machines were shipped to purchasers nationally. This is down from 32,065 machines shipped in 1976, most if not all no longer on location.

We submit that this data clearly supports the view that cigarette vending machines are the least likely retail source of cigarettes for persons ages 13 through 17.

Despite this data, the vending industry has long recognized its responsibility of preventing minors' purchasing cigarettes through vending machines. As early as 1962 the industry was asked to follow a 6-step self-regulation program designed to prevent the purchase of cigarettes by minors from vending machines. This program is constantly brought to the attention of N A M A members and operators of cigarette vending machines who are not members through collateral groups. These six steps, first adopted 27 years ago, are as follows:

Each vending machine operator should:

1. *Survey* his entire cigarette operation to determine the location of those *machines to which minors are likely to have access.*
2. *Post "Minors are Forbidden" warning decals* conspicuously on all machines.
3. Post on each machine the *name, address, and phone number of the operator.*

4. Solicit the *location owner's cooperation to prevent minors from purchasing* from machines to which minors have access. *Reposition machines, where necessary*, to assure adequate supervision.

5. *Remove machines from locations* where the sales of cigarettes to minors cannot be prevented.

6. *Cooperate with competitors to achieve area-wide compliance* of preventing the purchase of cigarettes by minors from vending machines. (As part of this step, establish local *group* liaison with police officials and offer cooperation in the enforcement of "sales to minors" laws).

As is evident from the Response Research study, cigarette vending machines have no discernable influence on teenagers' smoking. Whether parents smoke is the most important influence on teenagers' smoking habits along with peers and other family members.

But as the Response Research study shows, most sales of cigarettes to minors are made over-the-counter and not by means of vending machines. Since most of the fifty states already have on their books laws which prohibit the sale of tobacco products to minors (a compilation is attached) it seems that the basic avenue of prevention is the rigorous enforcement of these laws, not the singling out of a particular method of retailing. The vending industry supports rigorous enforcement. However, these laws that prohibit the sale of tobacco products to minors, generally under the age of 18, have been on the books for decades with little actual enforcement. Past experience seems to dictate that the enforcement level will probably remain where it is.

Therefore, we feel that the major deterrent to preventing access is to eliminate the demand. Parental and school influence is the necessary ingredient to discourage youngsters from beginning to smoke. Once the habit is adopted, strict law enforcement will likely prove ineffective. Education is the key, starting in the home. As has been pointed out, study after study shows that the major influence on teenagers as to whether they begin smoking is whether their parents smoke and what are their close peer groups doing.

The only other alternative is the suppression of retail sales of cigarettes to anyone, a position that few seriously advocate. Tobacco began with the birth of the colonization of America. Its roots are deep in our society - too late to prohibit its farming or use.

The vending industry continues to recognize its responsibilities through self regulation (even though the vast majority of our machines is located where teenagers do not have access to them and the current Response Research study shows that few teenagers purchase from vending machines). The vending industry took the lead voluntarily over 27 years ago to prevent teenagers from buying cigarettes. It stands ready to continue to cooperate with all groups to make sure that its record of responsible conduct and compliance with established laws is maintained in fact and in spirit.

Thank you for this opportunity to express our views.

RESPONSE RESEARCH STUDY

of

TEENAGE CIGARETTE SMOKING AND PURCHASING BEHAVIOR

The 1980's have witnessed a substantial change in the American Public's attitude toward smoking cigarettes. Along with this attitude switch have come new laws regulating smoking. This has had an impact on the companies and organizations which are associated with the selling of cigarettes. N A M A, which is the national trade association of the merchandise vending machine industry, is one such organization which has been affected by this attitude change. It is specifically concerned about proposals to ban the sale of cigarettes through vending machines. The rationale for such a ban is the allegation that many teenagers purchase cigarettes from vending machines. As a result, N A M A commissioned Response Research, an outside, independent marketing firm located at 500 North Michigan Avenue in Chicago, Illinois 60611, to conduct a survey to determine how and where teenagers ages 13 through 17 who smoke currently obtain cigarettes. The study also makes findings about what influences teenagers to begin smoking.

It is hoped that the findings presented here will assist interested organizations and lawmakers in getting factual and current data regarding the involvement of vending machines in the smoking habits of teenagers.

FINDINGS

STUDY OF TEENAGE CIGARETTE SMOKING AND PURCHASING BEHAVIOR

June/July 1989

Introduction

This study was conducted to determine how and where teenagers who smoke currently obtain their cigarettes. More specifically, this study was done to measure the following:

the extent to which teenagers obtain cigarettes by purchasing them, and

the portion of the cigarette purchasing that is done through vending machines.

Methodology

This was a mall intercept study which surveyed 1015 males and females between the ages of 13 and 17 who smoke cigarettes. The number of teens interviewed from each age group mirrored the 1987 Census Data of the teenage population. Additionally, half of the interviews were conducted with females and half were conducted with males.

In order to obtain a geographically dispersed sample of teens, the study was conducted in twenty cities throughout the U.S. Two different mall locations were used in each city. One mall was located in an average to above average income area and the other was in an average to below average area. This was done to get the best possible representation of different socioeconomic areas.

Overall Findings

This study found that vending machines are not a primary source of cigarettes for teenagers. When teens first start smoking, they rely heavily on their friends for cigarettes. After this initial phase, the main source of cigarettes for teens is an over-the-counter location.

Detailed Findings

Initial Smoking Behavior

- On average, the teens included in this study started smoking at the age of thirteen. There was not a lot of difference between the males and females as to when they started smoking.

- The teens were asked to express in their own words the reasons why they started smoking. They indicated that the primary motivator was knowing someone else who smoked (58%). This other person was usually a friend (42%). Social pressure also played a role in the teens' trial of cigarettes (30%).

- Friends who smoked were both the main reasons why others started and the main source of cigarettes for these new initiates. Almost three in five of the teens (57%) said that their main source of cigarettes when they first started smoking was their friends. Unlike the others, the teens who started smoking before they were ten years old were equally likely to rely on their friends and on family members for cigarettes.

- Most of the teens who primarily got their cigarettes by purchasing them when they first started smoking bought them over-the-counter (84%) and not from a vending machine (only 16%).

Current Cigarette Consumption

- The teens were asked about their daily and weekly cigarette consumption. On average, these teens smoked half a pack of cigarettes the day before the interview. Additionally, the average male smoked more (11 cigarettes) than the average female (9 cigarettes).

- As can be expected, the younger teens smoked less than the older teens. In fact, the 17 year olds smoked twice as many cigarettes as the 13 year olds (14 cigarettes vs. 7 cigarettes on average).

- The number of cigarettes that the teens reported smoking in the week before the interview was slightly less than seven times their reported daily consumption. On average, the males smoked just over 3 and a half packs (73 cigarettes) and the females had smoked just over two and a half packs (56 cigarettes); while the youngest teens smoked about half as much as the oldest teens (13 year olds--45 cigarettes and 17 year olds--88 cigarettes).

Current Source Of Cigarettes

- While friends were initially the primary source of cigarettes, this is not the case beyond the first phase of smoking. The most frequently used source of cigarettes is to purchase them. Nearly three-quarters of the teens (72%) reported that they bought cigarettes more often than they used other methods of obtaining cigarettes. Furthermore, there was little variation on this measure between males and females. However, the older teens were more likely than the younger ones to buy cigarettes frequently (60% of 13 year olds vs. 85% of 17 year olds). And, very few of the 17 year olds (5%) never buy cigarettes.

- While friends are not the primarily source of cigarettes once teens have established their smoking habit, they are an important secondary source. Almost half of the teens (45%) rely on friends occasionally for cigarettes. Friends are of particular importance to the younger teens. Almost four out of five 13 year olds (79%) go to their friends often or occasionally for cigarettes.

- Family members are not a significant source of cigarettes for teens regardless of their age.

Cigarette Purchasing Behavior

- Frequent Purchasers, those who buy cigarettes often or occasionally, rely much more on over-the-counter sources than on vending machines. Almost two-thirds of the Frequent Purchasers (64%) buy over-the-counter often whereas only one in eleven (9%) buys from a vending machine often.

- Over-the-counter sources are used more by the older teens than by the younger teens. Over three-quarters of the 17 year olds (78%) buy over-the-counter frequently whereas only half (46%) of the 13 year olds do.

- Those who purchase over-the-counter often or occasionally cited four locations as the ones they go to most frequently: convenience stores (43%), gas stations (29%), grocery stores (11%) and drug stores (6%).

- As mentioned, less than one in eleven Frequent Purchaser uses a vending machine often. In fact, over three-quarters of the Frequent Purchasers (78%) seldom or never buy from a vending machine. Of course, this varies by age. The 13 year olds are the most likely to use vending machines (22% do so often) and the 17 year olds are the least likely (2% do so often).

- The primary location of the vending machines used by teens is a restaurant or other eating establishment. Almost half (47%) of those who buy from a

vending machine often or occasionally go to a restaurant most often. Bowling alleys (11%) and gas stations (11%) are also popular locations.

- Those who use over-the-counter locations often or occasionally gave their reasons for this usage. There were three main reasons:

  they are convenient (31%),

  they will sell them to the teens (18%), and

  they prefer these locations because they dislike vending machines.

- Those who seldom or never bought over-the-counter did not buy from this source more frequently primarily because they were underage and felt they would be asked for an ID or hassled in some other way (59%).

- Teens who bought from vending machines often or occasionally found this source to be attractive because no one will stop them from buying cigarettes this way (56%).

- The teens who seldom or never bought from vending machines did not buy there because they felt that these machines were not conveniently located (48%) and cigarettes in machines were more expensive than those sold in stores (35%).

Difficulties Encountered When Trying To Buy Cigarettes

- The teens who buy cigarettes (often, occasionally or seldom) were asked if they had ever been prevented from buying cigarettes. Three in five of them had, with more 13 year olds having been refused (71%) than 17 year olds (50%).

- Those who had been refused were asked if they had been refused when buying over-the-counter and/or from a vending machine. Virtually all of these teens (98%) had been refused when buying over-the-counter, while about one in nine (11%) had been prevented from buying from a vending machine for a reason other than that the vending machine was broken.

Teen Awareness Of Cigarette Purchasing Laws

- Three-quarters of the teens (76%) were aware of a state law which prohibited certain kinds of people from buying cigarettes. When asked what the law said almost everyone (95%) indicated that it required the residents to be a certain age in order to buy cigarettes.

Parental Awareness and Approval Of Their Teenager's Smoking

- The teens were asked who else in their family smoked. Only 15% said that no one else did. Almost half of the teens had a father and/or mother who smoked (49% and 45%, respectively).

- As a way of determining whether or not their parents were aware of their smoking and approved of it, the teens were asked if they were permitted to smoke at home. Almost two in five teens (38%) were allowed to. The portion of teens who could smoke at home varied by age. Less than a quarter of the 13 year olds (22%) were able to while over half of the 17 year olds (54%) could.

- Additionally, almost half (45%) of the teens were permitted by their parents to purchase cigarettes. This too, varied by the age of the teen. Almost two-thirds (64%) of the 17 year olds were permitted to while only a quarter of the youngest teens could.

- When asked where they got the money for their cigarettes, three main sources came up: a job (63%), from parents/mom/dad (26%), and from one's allowance (26%). Since the older teens are the most likely to hold jobs, this was their primary source of cigarette money, wheras the younger teens relied more on their allowance and their parents.

The complete study including the questionnaire and methodology used and a description of the pretest is available upon request at a price of $20 from the National Automatic Merchandising Association, 20 North Wacker Drive, Chicago, Illinois 60606.

STATE STATUTES PROHIBITING THE SALE OF CIGARETTES TO MINORS

The following states prohibit the selling, giving or other furnishing of cigarettes to minors:

Minors under the age of 21

Pennsylvania - 16 for other tobacco products

Minors under the age of 19

Alaska, Alabama, Utah

Minors under the age of 18

Arizona
Arkansas
California
Colorado (all tobacco products)
Connecticut
Florida
Hawaii
Idaho
Illinois
Indiana (all tobacco products)
Iowa (all tobacco products)
Kansas
Kentucky
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey (all tobacco products)
New York
North Dakota
Oklahoma
Oregon
Rhode Island
South Carolina
South Dakota (16 for other tobacco products)
Tennessee
Texas
Washington
West Virginia
Wisconsin
Wyoming
Wisconsin

Minors under the age of 17

Delaware, Georgia, North Carolina, Vermont

Minors under the age of 16

District of Columbia
Maine
Virginia

States with no prohibitions against sales to minors

Louisiana
Montana
New Mexico

The following states require a posting of the law forbidding the sale of cigarettes to minors in each place of business where cigarettes are sold or on each cigarette vending machine.

California
Colorado
(including other tobacco products)
Connecticut
Florida
Hawaii
Indiana
(including other tobacco products)
Maryland
Massachusetts
Michigan
Minnesota
New Hampshire
New Jersey
New York
Ohio
Oregon
Rhode Island
Tennessee
Texas
Utah
Vermont
Virginia

The following states forbid minors from either smoking, buying, receiving, or possessing cigarettes.

Alaska
Arizona
Colorado
Idaho
Hawaii
Illinois
Kansas
Kentucky
Michigan
Minnesota
Missouri
Nebraska
New Hampshire
North Dakota
Rhode Island
Tennessee
Utah
Virginia
West Virginia

The following states require the minor to disclose where and from whom cigarettes were obtained.

Florida
Iowa
Kentucky
Oklahoma
South Carolina
West Virginia
(disclosure is a defense for minor)

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The following states forbids the placement of tobacco vending machines accessible to persons under a certain age.

Alaska - under 19

(machines considered accessible except (1) places where persons under 19 not allowed unless accompanied by a persons 19 or over as a matter of policy (2) places where persons under 21 not allowed by law unless accompanied by parent or guardian (3) a location that is generally supervised by a person who owns machine or location or an employee of same during hours machine is accessible.)

Idaho - under 18

(machines may not be accessible to minors under 18 years of age).

Indiana - under 18

A person may not distribute or sell tobacco by use of a coin machine or install or maintain a coin machine intended to be used for the sale or distribution of tobacco. Does not apply to coin machine located in the following: (1) part of a licensed premise where entry is limited to persons who are 18 years of age or older; (2) private clubs if membership limited to persons who are at least 18; (3) private industrial or office locations that are customarily accesssible only to persons who are at least 18; (4) a location where the vending machine can be operated only by the owner or an employee who is at least 18. The vending machine can be operated directly or through a remote control device if the device is inaccessible to all customers.

Minnesota - under 18

Tobacco can be sold by vending machines in an area with a factory, business, office, or other place not open to the general public or to which persons under 18 are not generally permitted access; in an on-sale alcholic beverage establishment or off-sale liquor store if the vending machine is located within the immediate vicinity, plain view, and control of an employee and the vending machine is not located in a coatroom, restroom, unmonitored hallway, outer waiting area or similar unmonitored area and the vending machine is inaccessible to the public when the establishment is closed. In other locations only if operable by activation of an elec-

tronic switch operated by an employee of the establishment before each sale, or by insertion of tokens provided by an employee of the establishment before each sale.

Utah - under 19

Gift or sale of cigarettes or tobacco in any form through vending machines or tobacco product machines is prohibited in this state except (a) at a bar, or a privately owned and operated club or association that has a private club liquor license under Chapter 5 to Title 32A, or that requires membership and charges a membership fee; (b) at a workplace serving adult employees in an area not available to the general public.

Sale by vending machine prohibited

Colorado - Prohibits entirely the sale of smokeless tobacco by use of vending or other coin-operated machine.

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Maine GROCERS ASSOCIATION

Serving the retail grocers of Maine

1 Western Court Street P.O. Box 5460 Augusta, ME 04330 • 207-622-4461

May 22, 1990

Mr. John Bagrosky
Executive Secretary
Interagency Committee on
Smoking and Health
Park Building, Room 1016
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Bagrosky:

As the representative of the Maine Grocers Association, I would appreciate an opportunity to offer my association's perspective at your May 31 meeting. I understand that the subject of that day's discussion will be the sale of tobacco products to minors.

During the past two years, the Maine Grocers Association has taken positive steps to limit the opportunity for minors to purchase or receive tobacco. Similar efforts have been undertaken in Vermont, Connecticut and New Hampshire. I think these efforts have proved to be very successful.

Because these efforts have the same purpose, and in an effort to save the Committee's valuable time, I suggest that I appear with my Connecticut, New Hampshire, and Vermont colleagues in a panel to discuss our positive efforts.

I look forward to hearing from you so that I can make my travel plans.

Sincerely,

John J. Joyce
Executive Director

2026172527

Vermont Grocers' Association, Inc.

Serving the food industry of Vermont since 1934

May 21, 1990

Mr. John Bagrosky
Executive Secretary
Interagency Committee on
Smoking and Health
Park Building, Room 1 - 16
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Bagrosky:

As the representative of the Vermont Grocers' Association, I would appreciate an opportunity to offer my association's perspective at your May 31 meeting. I understand that the subject of that day's discussion will be the sale of tobacco products to minors.

During the past two years, the Vermont Grocers Association has taken positive steps to limit the opportunity for minors to purchase or receive tobacco. Similar efforts have been undertaken in Maine, Connecticut and New Hampshire. I think these efforts have proved to be very successful.

Because these efforts have the same purpose, and in an effort to save the Committee's valuable time, I suggest that I appear with my Connecticut, New Hampshire and Maine colleagues in a panel to discuss our positive effrots.

I look forward to hearing from you so that I can make my travel plans.

Sincerely,

Jim Harrison,
President

ccs: John Dumais, NH Retail Grocers Association
John Joyce, Maine Grocers Association
Grace Nome, Connecticut Food Association

2026172528

33 Lafayette Street
Rutland, Vermont 05701-4146

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STATEMENT

OF

CONNECTICUT FOOD ASSOCIATION
MAINE GROCERS' ASSOCIATION
NEW HAMPSHIRE RETAIL GROCERS' ASSOCIATION
VERMONT GROCERS' ASSOCIATION

BEFORE THE

INTERAGENCY COMMITTEE ON SMOKING OR HEALTH

The subject of tobacco sales to minors has been the subject of much debate and discussion at all levels of our society. Parents are correctly concerned about their childrens' access to the product. Public officials at the local, state and national levels of government are attempting to assess the proper role of government in this area. However, no one is more concerned and more acutely aware of the issues and the need to responsibly address those issues than the retailers who sell the product to the public.

As the representatives of the more than 10,000 retail grocery stores in Connecticut, Maine, New Hampshire and Vermont, we are here today to provide the Committee with information about our efforts to comply with our existing state statutes regarding the sale of tobacco products to minors; and to suggest alternatives to the sometimes overly restrictive and often economically disruptive suggestions that have been offered as possible responses to the perceived problem.

It is not our intention to suggest that either the several states or the federal government should ignore the situation. Neither, do we suggest that those who would support the implementation of new and stringent legislation should abandon their concerns. Rather, we propose that the legitimate efforts of the retail merchants of tobacco products should be recognized and supported by our federal, state and local units of government.

POSITIVE COMMITMENT

What is that commitment? Let's explore what has been attempted and accomplished by our organizations and their members during the past two years:

1. A commitment to endorse and support an eighteen year old minimum sales age for tobacco products:

A. Of our states, only Vermont still enforces a minimum sales age lower than eighteen (18) (seventeen (17)) years of age. During the 1990 session of the Vermont state Legislature, the Vermont Grocers' Association supported H771 which would have increased the minimum sales age to eighteen (18) years of age;

B. Legislation would prohibit an adult from causing a minor to purchase tobacco products.

2. A commitment to educate retailers about the minimum sales age, and encourage education of sales clerks with regard to methods to ensure that sales are only to authorized adults;

A. Creation of uniform signage for distribution to all members of the retail trade regarding the minimum sales age statutes;

B. Support for legislation in Maine, New Hampshire and Vermont that would remove the previously unfulfilled burden for distribution of signage from the Secretary of State's office. Placing that burden on the individual retailer.

3. Education of retail owners regarding minimum sales age laws and penalties for violation;

A. Seminar on the subject at annual trade meetings; and part of our ongoing alcohol and tobacco training programs;

B. Distribution of signs, law text and guidelines at annual trade meetings;

C. Periodic reinforcement of message through regular association publications.

4. Education of retail store clerks regarding the law and their part in enforcement;

A. Distribution of materials for use by store owners.

Similarly, our organizations have supported reasonable, escalating penalties for retailers who knowingly sell tobacco products to minors.

RECENT PROPOSALS

In recent days the Secretary of Health and Human Services has suggested model legislation for discussion by the states with regard to cigarette sales to minors. While well intentioned, we feel the proposals go too far and fail to acknowledge our concerns, the realities of the marketplace and existing laws.

The Secretary suggests an "alcohol-type" licensing system. This is unworkable. Tobacco sales can represent up to 25% of a retailer's gross sales. The imposition of a licensing structure that would require selective siting, community approval and restricted availability, as with alcohol, would mean some retailers would not survive. Some states, New Hampshire and Vermont for example, restrict some alcohol sales to state-operated stores. Other sales licenses are restricted to retailers in remote locations where state-run operations would not be profitable.

The suggestion also ignores the fact that many retailers currently hold licenses related to tobacco sales. These are controlled by their states' departments of revenue and are related to their tax collection responsibilities. New punitive licensing is not necessary.

An area totally ignored by the Secretary's proposals is that of responsibility. The sale of tobacco products to minors requires at least two parties -- the seller and the buyer. In some cases a third party, an adult sending a minor to purchase cigarettes for their use, intervenes in the process. However, all of the burden for responsible action rests on the shoulders of the seller. This is unfair.

The minor and the adult purchaser should bear some responsibility for the transaction. We would suggest the enactment of laws that "prohibit the purchase of tobacco products by minors." Similarly, we would and have supported laws that would "prohibit an adult from causing a minor to purchase tobacco products."

Laws prohibiting minors to purchase tobacco products have been enacted, at our suggestion, in Maine and New Hampshire. Similar laws have been proposed in Vermont, Connecticut and Massachusetts, but have been rejected by the legislatures in those states.

Laws prohibiting an adult from causing a minor to purchase tobacco products have been proposed in Massachusetts. In Vermont, we have supported repeal of state laws allowing a minor to purchase tobacco with the approval of an adult. This was rejected.

CONCLUSION

It is our opinion that we in the retail trade have accepted our responsibility for keeping tobacco products out of the hands of minors. Are we always successful? -- no. Unfortunately we, like the government, are only human and we fear that perfection will always elude us. However, we have recognized the concern and have been taking positive steps to address it for more than two years. We ask that the public and the government take note of those positive accomplishments.

There are others who should share the responsibility for keeping tobacco products out of the hands of children. These include:

A. The government

1. Enforce existing laws;

2. Assist in the effort to educate retailers.

B. The minor

Enact laws placing a portion of the responsibility on the minor and on adults who cause the minors to purchase tobacco products.

We have accepted our responsibility. Now it is time for others to accept their portion before the enactment of new laws that jeopardize the ability of a small businessman to earn a living and place them in jeopardy of criminal sanction. We would be happy to work with the Committee to develop a fair and workable plan.

John Dumais
Executive Vice President
New Hampshire Retail
Grocers' Association

John Joyce
Executive Director
Maine Grocers' Association

James Harrison
Executive Vice President
Vermont Grocers' Association

Grace Nome
President
Connecticut Food Association

2026172532

Statement by
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
to Interagency Committee on Smoking and Health
May 31, 1990
"Preventing the Sale of Tobacco to Children"

The Association of State and Territorial Health Officials is made up of the chief health officials of the public health agency of each State, Territory, or Possession of the United States. ASTHO's goals include formulating and influencing sound national public health policy and serving state health departments in developing and implementing state programs and policies for the public's health and the prevention of disease. ASTHO has singled out several issues for special consideration because of their importance to public health. Tobacco-related issues have been identified as a special ASTHO concern. ASTHO is pleased to have this opportunity to share our views on the sale of tobacco to children with the Interagency Committee on Smoking and Health.

Recognizing that tobacco use is the largest cause of preventable disease in this country, public health officials are committed to policies and programs to reduce and prevent the use of tobacco. The ASTHO Committee on Tobacco or Health has published the Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans. The Guide is intended to assist state and local health agencies in developing their own comprehnsive tobacco use and prevention plans. ASTHO also sponsored a conference earlier this year for health department officials involved in tobacco issues to improve the public health practice of tobacco prevention and control. Children and youth are a major target group for prevention activities.

The goal of tobacco-related programs must be to assure that the number of current smokers continues to decline and that no new smokers are added. Preventing non-smokers--primarily children and teenagers--from starting to smoke or chew tobacco is a different task from helping people who already use tobacco to stop.

Tobacco use starts early. Almost one-quarter of smokers start before age 16, over half by age 18, and nearly 90 percent before age 21. The age at which smoking begins has been moving down over time; a greater proportion of children are starting to smoke at an earlier age than ever before.

A comprehensive spectrum of policies is needed to address use of tobacco by children. The best way to prevent sales of tobacco to children is to keep them from even trying to buy tobacco. If children don't want to buy tobacco, then sales prevention is not an issue. Tobacco must be made unattractive to children. Education and counteradvertising are the best tools to make tobacco unattractive. Limitations on advertising and sports and other promotions sponsored by tobacco products are additional tools for keeping tobacco from becoming attractive.

Peer influences have much to do with adolescent smoking. One survey found that ninth grade boys and girls were 15 times more likely to smoke if their best friend smoked and ninth grade boys were about 20 times more likely to use smokeless tobacco if their best friend did also. Commercial tobacco advertising, although nominally not aimed at adolescents, also exerts pressure by showing attractive people smoking in attractive settings. The message, which is not missed by young people searching for role models and an identity, is that successful, vibrant, popular adults smoke.

To counter these influences, some states have used mass media campaigns. In Minnesota, for example, the health department has developed paid advertising campaigns aimed at adolescents emphasizing the social consequences of chewing and smoking such as bad breath and tobacco-stained teeth, as well as personal consequences such as addiction and the expense of tobacco. Follow-up research has shown that children exposed to the counter-advertising have changed their attitudes about tobacco.

Tobacco companies spend billions of dollars each year to promote their product. This level of effort from the companies must have an effect on the perception of young people about the social acceptability and desirability of tobacco use. Proposals to regulate or restrict the content of tobacco advertising and to limit or prohibit the distribution of advertising are being given serious consideration. Reducing the volume and glamor of advertising would help provide some balance to the struggle for the health and mindset of young people.

Education efforts in the schools are important in preventing children from starting to use tobacco. Well designed curricula, based on research about what works, need to be widely disseminated and implemented. The trend in smoking prevention activities aimed at children has been to target increasingly younger children, now focusing on middle school and junior high school, and to use programs which address smoking motivation and ways to resist temptations.

In addition to direct advertising, tobacco companies use sponsorship of sports events and public functions as a way of keeping their brand names before the public and fostering a positive image. They also make funds available to public schools for special programs. Although the companies claim that these efforts are primarily good corporate citizenship and not intended as a form of advertising, such assertions lack credibility. As a newspaper columnist recently wrote in commenting on the controversy over a tobacco company grant to the the District of Columbia public schools, if the donor did not intend to publicize its tobacco products, it could have made the grant under the name of another non-tobacco company under its corporate umbrella.

The promoter of a sporting event, the school system starved for funds, and others who accept sponsorship and funding from tobacco companies have a dilemma. The purposes are valid and worthy, but

they should not be coopted by tobacco companies seeking respectability. By attaching their name to good community causes, the tobacco companies divert attention from the harm that they do every day in those same communities. Additionally, the community leaders who have benefited from the "generosity" of the tobacco companies find it more difficult to speak out against the dangers of tobacco use. The free publicity and good will that tobacco sponsorship generates must be curbed.

Pricing policy is another way to keep children from buying tobacco. Young people are more affected by the price of tobacco products than other groups. Studies have shown that the demand for cigarettes by teenagers is more strongly affected by price than is the demand by adults. A few cents additional on a package of cigarettes is sufficient to discourage a young person from buying them. An increase in the federal excise tax on tobacco would have the beneficial effect of keeping many children from buying that first pack of cigarettes or chewing tobacco.

Policies to encourage aversion to tobacco or disinterest are important and the most desirable ways to prevent sales to children. But some children are still going to want to experiment or defy adult values. For these children, policies which directly address sales are needed. All but six states have laws which set a minimum age for tobacco sales. However, most of these states have no penalties for vendors who sell tobacco to underage children. Even when penalties are provided, enforcement is lax to non-existent. Studies of compliance have shown that minors can readily purchase tobacco products, regardless of the legal restriction. And if restrictions on store sales to children are ineffective, then the few restrictions on vending machine sales are laughable.

Prohibitions on sales of tobacco to children must be given a high priority. The nation has made a strong effort to restrict the sale of liquor to minors and has seen a concomitant reduction in the number of drunken driving deaths of teenagers. While much remains to be done with regard to teenage alcohol abuse and drunk driving, the high visibility given to this problem has shown results. The long term health consequences of teenage tobacco use are more devastating than those from alcohol. A much stronger effort is needed to curb tobacco sales to children and teenagers. The age for legal purchases needs to be reduced. Severe penalties must be enacted and enforced for violations by retailers. And penalties should also apply to the children themselves, not the retailers alone. Retailers must be educated about the law. They must be required to post signs about the age restrictions. Vending machines must be regulated so that children cannot circumvent the sales restrictions by turning from salespeople to machines.

Lawmakers, law enforcers, retailers, and society in general must face up to the harm that is caused by selling tobacco to children. Society needs to direct some of the outrage that society expresses to illegal drug dealers who sell to children to fight tobacco sales to children.

2026172536

MODEL SALE OF TOBACCO PRODUCTS TO MINORS CONTROL ACT

A Model Law Recommended for Adoption
by States or Localities
to Prevent the Sale of Tobacco Products to Minors

U.S. Department of Health and Human Services
May 24, 1990

Introduction

The great majority of states prohibit sale of tobacco products to minors. Yet over one million teenagers start smoking each year, and minors buy about one billion packs of cigarettes each year. Because nicotine is an addicting drug, a minor who starts smoking is likely to be a lifelong customer--and one in four will die prematurely of lung cancer or other smoking-related disease. Illegal tobacco sales dwarf illegal alcohol and hard drug sales to minors, and the resulting mortality is many times greater--390,000 deaths a year. These are preventable deaths, and many of them occur because youth can obtain tobacco products with ease. Over eighty percent of teenagers correctly believe that it is very easy for them to buy cigarettes.

Access of minors to tobacco is a major problem in every state of the nation. About three-fourths of the million outlets which sell cigarettes to adults also sell cigarettes to minors. These stores ignore the laws of their states because enforcement is almost non-existent. Many retailers are even unaware that such sales are illegal. Yet there are straightforward enforcement approaches which can eliminate almost all sales to minors while yielding revenues to cover the cost of enforcement. Teenage smoking can be greatly reduced without disruption either to governments or to sales to adults.

Data on the nature and extent of the enforcement problem, and information on successful community efforts to prevent illegal sale of tobacco products to youth, are presented in the report of the Office of the Inspector General titled "Youth Access to Cigarettes," dated May, 1990. Additional information on this issue can be obtained from the Office on Smoking and Health, within the Centers for Disease Control of the Public Health Service.

The Department of Health and Human Services has reviewed options for improving enforcement. The approach we have developed is embodied in a draft model law. We recommend that each of the 50 states enact this model. No state now uses all of the tools needed to make enforcement effective. In states which are not immediately willing to adopt the model law, counties and cities can enact most features by ordinance and prevent children's access to tobacco products.

No enforcement scheme is perfect. Many of those who are already addicted will find ways to get tobacco to meet their craving for nicotine. But for most teenagers, easy access to tobacco products and addiction can be eliminated. For others, reductions in frequency and numbers of cigarettes smoked will decrease the likelihood of becoming long-term smokers.

Summary of the Model Law

The model law has several key features. These are summarized below and discussed further in the section-by-section analysis. Some of these features can and should be modified by each state to reflect its internal organization and processes. But the underlying approaches, however implemented, are key to effective enforcement. The model law would:

- o Create a licensing system, similar to that which is used to control the sale of alcoholic beverages, under which a store may sell tobacco to adults only if it avoids making sales to minors. Signs stating that sales to minors are illegal would

be required at all points of sale.

o Set forth a graduated schedule of penalties--monetary fines and license suspensions--for illegal sales so that owners and employees face punishment proportionate to their violation of the law. Penalties would be fixed and credible. Those who comply would pay only a license fee.

o Provide separate penalties for failure to post a sign, and higher penalties for sales without a license.

o Place primary responsibility for investigation and enforcement in a designated state agency, and exclusive authority for license suspension and revocation in that agency, but allow local law enforcement and public health officials to investigate compliance and present evidence to the state agency or file complaints in local courts.

o Rely primarily on state-administered civil penalties to avoid the time delays and costs of the court system, but allow use of local courts to assess fines, similar to traffic enforcement. This would provide flexibility to both state and local authorities to target enforcement resources. (An illegal sale could not result in two fines, but a local conviction would be reported to the state and count towards possible license suspension).

o Set the age of legal purchase at 19. This is higher than under many existing state tobacco statutes, but lower than the age for alcohol. States may wish to consider age 21, because addiction often begins at ages 19 and 20, but rarely thereafter.

o Ban the use of vending machines to dispense cigarettes, parallel to alcohol practice and reflecting the difficulty of preventing illegal sales from these machines. (This is another area where states should examine options carefully; allowing sales in places not legally open to minors, or use of store-controlled electronic enabling devices, may be acceptable alternatives. States could also consider phasing of the ban to minimize disruption.)

o Contain a number of features to minimize burdens on retail outlets: requiring identification only for those who are not clearly above the age of 19, allowing a driver's license as proof of age, setting a nominal penalty for the first violation, disregarding one accidental violation if effective controls are in place, having the state provide required signs, and setting license fees lower for outlets with small sales volume.

The model law does not explicitly address several topics, including possession of tobacco by minors, earmarking revenues for enforcement, allowing local ordinances to be stronger than the state law, and authorizing use of minors in "sting" operations to detect violations. This does not mean that states should not consider including such provisions, as discussed further below, but that we did not believe them necessary or appropriate within the statute. For example, use of stings will be vital to effective enforcement of this law, but like other investigative procedures need not be detailed in statute.

In summary, the model law attempts to create workable procedures which will provide retail outlets the incentive and tools to refuse to sell to minors, as already required by law in almost all states. Stores which comply will have no burden other than a licensing fee and, in some cases, replacement of vending machine by over-the-counter sales. Compliance by responsible stores, which would quickly become the great majority, will enable state and local authorities to concentrate enforcement efforts on a small number of recalcitrant outlets. The few stores which are unable or unwilling to prevent sales to minors may elect to stop carrying tobacco products, or will lose the license to sell tobacco products. Adults will continue to be able to buy cigarettes and other tobacco products at a wide range of outlets.

Ultimately, the effectiveness of this legislation depends on the willingness of concerned citizens to report violations to authorities who are responsible for taking investigatory and, if necessary, enforcement action. We are sure that enough citizens are concerned; the model law simply provides an effective and efficient system to handle their complaints, filling voids in almost all state enforcement schemes. Indeed, merely putting an effective enforcement mechanism in place is the single most important reform. The better the mechanism, the less likely it will have to be used.

Section-by-Section Analysis

Section 1 states the title of the bill, here suggested as "Sale of Tobacco Products to Minors Control Act."

Section 2 presents appropriate findings of fact. Most important, in this context, are that tobacco products are addicting, that addiction almost always starts in teenage years, and that smoking causes death on a large scale. States exploring these issues may wish to consult recent reports of the Surgeon General, which summarize and synthesize the large body of knowledge extant.

Section 3 establishes a state "Office of Tobacco Control" and the key powers of that office. Whether that office would best be located in the Department of Health or the state alcohol sales licensing agency, or established as an independent agency, is uniquely a matter for state-specific decision.

Two key provisions of section 3 require the Office to operate a licensing system and to prepare and distribute to licensed outlets signs concerning sales to minors. Requiring a license for sale of tobacco products conditions the privilege of sale on compliance with the law. Later in the bill heavy penalties are provided for any sales (or free distribution) to any persons without such a license. Failure of licensed outlets to prevent sale to minors leads to financial penalties and revocation of the license. The text is worded to allow licensing mobile vendors--it is not the purpose of the law to harm any small businesses.

The state agency is empowered to investigate and enforce the law. The investigative and enforcement techniques are not specified in detail, since these are generally routine and well-established administrative functions. However, the most powerful technique for both investigation and enforcement will in most circumstances involve testing compliance

by sending underage persons to stores which sell tobacco products--especially those have been reported for illegal sales. A request to purchase cigarettes is then made and the sale, if consummated, provides evidence of violation of the statute. Properly designed and supervised by state or local officials, such testing can readily and inexpensively establish whether an outlet violates the law, and provide the basis for a formal complaint and enforcement decision. States and communities now using this approach often hire teenagers to perform this function as temporary employees, to provide insurance protection to the teenagers and assure proper supervision. Depending on other law (e.g., whether possession by minors is illegal) and court rulings, some states may wish to authorize this approach explicitly. Tennessee does so now.

The model law provides that local officials may also investigate violations, and either assist the state agency by bringing evidence before it or bring cases directly in local courts. Local officials in some cities and counties will have the resources and expertise to contribute significantly to enforcement. Such contributions will not only speed enforcement directly, but allow the state agency to allocate its resources where they are most needed. In general, the assumption of the bill is that there will be substantial state and local cooperation, similar to the kinds of arrangements used for traffic violations. A varied local role in investigation and enforcement will also be useful in identifying techniques which are particularly effective within each state.

The license fee is suggested as $300 for most stores but only $50 for stores with a volume of tobacco sales below $5,000 a year. This should provide enough revenue to make enforcement budget-neutral, while protecting small businesses from what might be perceived as an onerous cost in relation to sales. Of course, enforcement costs will not necessarily vary by size of outlet and a state could balance these considerations differently. Regardless, a state could use additional distinctions (e.g., by size, or whether licensed to sell alcoholic beverages) or set these fees higher or lower; depending on other licensing systems, its revenue goals, and whether it wishes the tobacco control system to be fully financed through license fees. We have not suggested earmarking revenues to accrue directly to the Tobacco Control agency rather than the general fund, but some states might wish to do this.

Section 4 requires license holders to display the license and sign (section 7 provides a monetary penalty for failure to display them). A visible sign provides continuing notice to all --sales clerks, underage customers, and older customers--as to the law's requirements and the store's declared willingness to comply. The sign also aids clerks in refusing to sell to underage customers.

Section 5 provides that both licensees and their employees may not sell or give tobacco products to individuals known to be under the legal age, or to individuals who are not clearly older or who do not have appropriate proof of age such as a driver's license. It also bans entirely sales of "broken packs" (cigarettes are sometimes sold one-by-one to minors), vending machine sales, and sales other than at licensed outlets.

Two of these provisions raise significant questions. First, why age 19, when alcohol purchase is illegal below age 21 and most states now ban tobacco sales at age 18 or below? To the significant extent that tobacco, like alcohol, has been an adult privilege to which many teenagers turn at the first legal opportunity, raising the age will postpone

such exposure until the adolescent has reached an age at which mature judgment has a better chance of overcoming the intense pressure to experiment with "adult" behaviors. This postponement may be even more important for tobacco than for alcohol, since nicotine is rapidly addicting. Even a month or so of regular smoking is likely to create a lifelong addiction for most persons. Also, a realistic appraisal must concede that most teenagers a year younger than the legal age can readily obtain tobacco products from friends who can legally purchase them. Thus, an age 18 limit exposes most 16 and 17 year old youth to an easily exercised temptation. Only if the age limit is at least 19 can the state be confident that most high school students will not have ready access to tobacco. Of course, a few teenagers will be able to obtain such products from family or older friends; the issue here is ready access for most teenagers. Finally, only if the age limit is at least 19 will smoke-free school policies be fully enforceable--no students will have legal access to tobacco products. States are encouraged to consider age 21; this will parallel alcohol practice and also protect older teenagers during years in which many are still vulnerable.

Second, why ban vending machine sales? The basic problem with these sales is that they do not require human intervention--the active participation of a clerk who sells the product only after observing or checking age. Vending machines are often used now by adolescents, and vending machines will nullify otherwise effective action preventing over-the-counter sales. Sales personnel at a register cannot effectively police even nearby machines while serving other customers. Individual states may wish to consider two variations: allowing vending machine sales in places which minors may not legally enter at all, or electronic disabling devices which require positive action by a clerk to activate. However, Utah found that disabling devices were ineffectual in practice. Finally, states could consider allowing a grace period for elimination of these machines to minimize disruption.

Section 6 prohibits unlicensed sale or distribution of tobacco products. It allows exceptions for distribution by relatives or friends on private property not open to the public (e.g., the home) and for wholesale distribution. Section 7 provides for a fine of up to $1,000, and imprisonment of up to 30 days, for unlicensed sale or distribution.

Section 7 establishes two types of financial penalties for violations committed at licensed outlets--civil money penalties and fines. These financial penalties apply both to license holders and sales personnel. Sales personnel are subject to penalties both to emphasize their responsibility under the law and to protect employers against the carelessness of employees. Financial penalties rise progressively with repeated offenses, and are designed to avoid penalizing compliant stores for truly isolated lapses occurring over wide periods of time. A license holder may also avoid one penalty in any two year period by showing that an effective system to prevent violations is in place, i.e., that the sale was a true lapse. The suggested penalty for a first offense is $100 and no suspension; the fourth violation brings a $1,000 dollar fine and a 9 to 18 month suspension of the license. In effect, law abiding stores have nothing to fear; persistent offenders will lose the right to sell tobacco products to adults.

The Department of Health and Human Services has found that use of civil money penalties assessed through administrative law judges rather than the courts has greatly improved the effectiveness and efficiency of enforcing various statutes related to fraud

and abuse. The capacity of the Federal criminal justice system is so stretched that without the alternative of civil money penalties, many "minor" frauds or other crimes simply could not be prosecuted. States face similar constraints. Using civil money penalties is not an "either-or" choice--under existing Federal law, both civil and criminal remedies are available and the choice of which to use in particular cases greatly facilitates effective enforcement. The advantage of this added tool is not only case-specific but systemic: the mere existence of a credible and workable civil money penalty raises the potential cost of statutory violations, and thereby deters violations.

Although the model law emphasizes civil money penalties, fines are authorized as well to provide an enforcement role for both state and local authorities and to provide flexibility of approach. For any particular instance of noncompliance, only one financial penalty may be assessed. Any penalties assessed at the local level must be reported to the Tobacco Control agency so that this agency can accumulate records needed for license suspensions.

Thus, the model law allows the following kinds of flexibility:

o The Tobacco Control agency may develop a backlog of cases requiring hearings. If so, it may bring cases before a local court seeking fines rather than civil money penalties.

o A particular county may be a substantial distance away from agency offices and this may inconvenience retailers, witnesses, and enforcement personnel. The agency can reduce this inconvenience by using local courts.

o Some counties may have both investigator staff (e.g., county health officer) and court capacity to conduct an aggressive enforcement program, beyond the capacity of the state agency. If so, these counties can investigate and seek fines in the local courts. This will simultaneously improve enforcement in these counties and free up state resources for others.

The model law does not address disposition of proceeds from either civil money penalties or fines. Absent specificity, we assume that in most states the former would accrue to the state treasury and the latter to county or city treasuries. This provides an additional benefit of allowing either approach to enforcement: cities and counties can invest in enforcement without financial loss. Of course, a state could elect to earmark revenues differently.

Section 8 provides for license suspension, revocation, and nonrenewal. Starting with the second offense, there are progressively steeper periods of suspension: seven days for the second offense, up to 9 to 18 months for the fourth violation. Section 8 also provides for suspension of licenses for all outlets of a chain if more than three outlets have violated the law more than three times in a two year period. This provision creates a strong incentive for retail chains to ensure compliance by all of their outlets.

Other Matters. The model law does not prohibit purchase or possession of tobacco products by minors. Some states and communities already prohibit these and others may wish to consider this. We left out such provisions because in our judgment they

would be far harder to enforce--and of less relevance to preventing widespread availability--than prohibitions on sales. Such provisions also raise such issues as use of minors as sales clerks; establishment of enforcement procedures; establishment of penalties (small fines, community service, or attending smoking cessation programs are commonly proposed); and possible need to exempt purchase by minors in supervised "sting" operations. Regardless, any underage person smoking in public would indicate a potential violation of the sales ban even absent a possession or purchase law. Authorities could investigate the source of these tobacco products whether or not purchase or possession were banned. States willing to invest in enforcement for both sales and possession should consider adding possession prohibitions.

Finally, while the model law provides for a significant local role in enforcement, it does not provide for independent local statutes. States might wish to empower municipalities to levy higher fines or otherwise exercise some independent authority. The worst possible outcome would be to enact a state statute which failed to establish an effective and workable enforcement system while preempting local governments from filling this void.

Conclusion

Existing state laws prohibiting sales of tobacco products to minors have largely been ineffectual. This enforcement failure is hypocritical and contributes to a scoff-law environment. Unlike some other law enforcement problems, this is neither inherent or insuperable. Eliminating virtually all sales to minors does not even present particularly difficult enforcement problems. It simply requires workable procedures which create swift and sure sanctions for violations, with minimal cost or inconvenience to retailers and adult customers. There is a large and articulate body of citizenry--including a large proportion of teenagers and retailers--who understand the gravity of tobacco consumption as a public health problem and who would welcome reasonable laws. Enactment and responsible implementation of this model law is the single most important reform to improve the health of its citizens that any state could undertake in the decade of the 1990s.

MODEL SALE OF TOBACCO PRODUCTS TO MINORS CONTROL ACT

SECTION 1. SHORT TITLE.

This Act may be cited as the "Sale of Tobacco Products to Minors Control Act".

SEC. 2. FINDINGS.

The Legislature finds that--

(1) approximately 390,000 Americans die each year of diseases caused by cigarette smoking,

(2) the Surgeon General of the Public Health Service has determined that smoking is the leading cause of preventable death in this country,

(3) nicotine in tobacco has been found by the 1988 report of the Surgeon General, The Health Consequences of Smoking: Nicotine Addiction, to be a powerfully addictive drug, and it is therefore important to prevent young people from using nicotine until they are mature and capable of making an informed and rational decision,

(4) most adults who smoke wish to quit, a majority of current adult smokers have tried to quit without success, and one-half of all teenagers who have been smoking for five years or more have made at least one serious but unsuccessful attempt to quit,

(5) every day more than 3,000 minors begin smoking,

(6) one-half of smokers begin before the age of 18, and 90 percent begin before the age of 21, and

(7) minors spend more than one billion dollars on cigarettes and other tobacco products every year.

SEC. 3. OFFICE OF TOBACCO CONTROL.

(a) Establishment of Office.--There is established in the Department of _____ an Office of Tobacco Control. The Office shall be headed by a Director.

(b) Functions of Director.--The Director shall--

(1) issue licenses for the sale of tobacco products,

(2) provide without charge signs (concerning the prohibition on sales to individuals under 19 years of age) that meet the requirements of subsection (d) to persons licensed to sell tobacco products,

(3) investigate (concurrently with other State and local officials) violations of sections 4 through 6,

(4) enforce civil money penalties under section 7,

(5) enforce (concurrently with other State and local officials) fines under section 7, and

(6) bring license suspension, revocation and nonrenewal actions under section 8.

(c) Licenses.--

(1) A license for the sale of tobacco products shall be issued to a specific person for a specific outlet (a fixed location or mobile unit) and shall be valid for a period of one year.

(2) The annual fee for a license is $50 for an outlet whose annual volume of tobacco sales is less than $5000, and

$300 for an outlet whose annual volume of tobacco sales is $5000 or more.

(d) Signs Concerning Sales to Individuals Under Age 19.--Signs to be provided under subsection (b)(2) shall--

(1) contain in red lettering at least one-half inch high on a white background "IT IS A VIOLATION OF THE LAW FOR CIGARETTES OR OTHER TOBACCO PRODUCTS TO BE SOLD TO ANY PERSON UNDER THE AGE OF 19", and

(2) include a depiction of a pack of cigarettes at least two inches high defaced by a red diagonal diameter of a surrounding red circle.

SEC. 4. DISPLAY OF LICENSE AND SIGNS.

A person that holds a license issued under section 3(b)(1) shall--

(1) display the license (or a copy) prominently at the outlet for which the license is issued, and

(2) display prominently at each place at that outlet at which tobacco products are sold a sign that meets the requirements of section 3(d).

SEC. 5. PROHIBITIONS APPLICABLE TO LICENSE HOLDERS AND THEIR EMPLOYEES AND AGENTS.

(a) Prohibition on Sale or Distribution to Individuals Under the Age of 19 and in Certain Other Cases.--A person that holds a license issued under section 3(b)(1), or an employee or agent of that person, may not sell or distribute a tobacco product--

(1) to any individual that the license holder, employee, or agent knows is under 19 years of age,

(2) to any individual (other than an individual who appears without reasonable doubt to be over 19 years of age) who does not present a driver's license (or other generally accepted means of identification) that describes the individual as 19 years of age or older, contains a likeness of the individual, and appears on its face to be valid,

(3) in any form other than an original factory-wrapped package, or

(4) other than at an outlet for which a license has been issued under section 3(b)(1).

(b) Prohibition on Maintaining Vending Machines.--A person that holds a license issued under section 3(b)(1), or an employee or agent of that person, may not maintain at a licensed outlet any device that automatically dispenses tobacco products.

(c) No More Than One Violation on Any One Day.--No person shall be liable under the preceding subsections for more than one violation on any one day.

SEC. 6. PROHIBITION ON UNLICENSED SALE OR DISTRIBUTION OF TOBACCO PRODUCTS.

(a) General Rule.--No person, other than a person who holds a license issued under section 3(b)(1), or an employee or agent of that person, may sell or distribute a tobacco product.

(b) Exceptions.--Subsection (a) does not apply to--

(1) distribution by an individual to family members or acquaintances on private property that is not open to the public, or

(2) the sale or distribution to a manufacturer of tobacco products, to a wholesaler of tobacco products, or to a person who holds a license issued under section 3(b)(1).

SEC. 7. PENALTIES.

(a) Nature and Size of Penalties.--

(1) Any license holder that violates a requirement of section 4 shall be subject to a fine or civil money penalty of not more than $100.

(2) Any license holder, employee, or agent that violates a prohibition of section 5 shall each be subject to--

(A) a fine or civil money penalty of $100, for the first violation within a two year period,

(B) a fine or civil money penalty of $250, for the second violation within a two year period,

(C) a fine or civil money penalty of $500, for the third violation within a two year period, or

(D) a fine or civil money penalty of $1000, for any additional violation within a two year period.

(3) Any person that violates a prohibition of section 6 shall be subject to a fine of not more than $1000, or imprisonment of not more than 30 days, or both.

(b) Exception for License Holder.--A person that holds a license issued under section 3(b)(1) shall not be subject to a fine or civil money penalty under subsection (a)(2) for a violation by an employee or agent of a prohibition under section 5, and an assessment of a fine or civil money penalty under

subsection (a)(2) for a violation by an employee or agent shall be disregarded for purposes of section 8(a), if the license holder affirmatively demonstrates that the license holder has an effective system in place to prevent violations of the prohibitions under section 5. The exception prescribed by the preceding sentence applies only once to a license holder during any two year period.

(c) No Double Penalty.--

(1) If an action has been commenced against a person under subsection (a)(1) or (a)(2) for a particular violation for the payment of a fine, no action may be commenced against that person for that violation for the payment of a civil money penalty.

(2) If an action has been commenced against a person under subsection (a)(1) or (a)(2) for a particular violation for the payment of a civil money penalty, no action may be commenced against that person for that violation for the payment of a fine.

(d) Notification to Office of Tobacco Control of Fines Imposed.--A court shall notify the Director of the Office of Tobacco Control of any fine imposed under subsection (a)(2).

SEC. 8. SUSPENSION, REVOCATION, AND NONRENEWAL OF LICENSES.

(a) Suspension, Revocation, and Nonrenewal of Individual Licenses.--A license issued under section 3(b)(1) for a particular outlet shall be suspended or revoked, and not renewed, for a period of--

(1) 7 days, if a fine or civil money penalty has been imposed under section 7(a)(2) for the second violation at that outlet within two years,

(2) 1 to 6 months, if a fine or civil money penalty has been imposed under section 7(a)(2) for the third violation at that outlet within two years, or

(3) 9 to 18 months, if a fine or civil money penalty has been imposed under section 7(a)(2) for any additional violation at that outlet within two years.

(b) Suspension, Revocation, and Nonrenewal of All Licenses for Outlets Under Common Ownership or Control.--All licenses issued under section 3(b)(1) for outlets that are under common ownership or control shall be suspended or revoked, and not renewed, for a period of 9 to 18 months, if fines or civil money penalties have been assessed under section 7(a)(2) for three or more violations at three or more outlets within a two year period.

(c) No Double Counting.--A violation committed by an employee or agent, and attributed to a license holder, shall be counted only once for purposes of the preceding subsections.

(d) Exception.--See section 7(b).

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR RELEASE: 10 a.m., EDT
Thursday, May 24, 1990

Contact: HHS Press Office
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Calling for stronger efforts to prevent the sale of cigarettes to minors, HHS Secretary Louis W. Sullivan, M.D., today proposed model state legislation which would ban cigarette vending machines and provide for a licensing system similar to that used to control the sale of alcoholic beverages.

Secretary Sullivan cited a report released today by the HHS Inspector General which found that while 44 states have laws prohibiting cigarette sales to minors, little effective enforcement of these laws is carried out.

"These laws are being blatantly ignored," Dr. Sullivan said in testimony before the Senate Finance Committee. "We have found it convenient to look the other way as cigarettes are openly sold to our nation's youth."

The report said that in a summary survey, only five of the 44 state law enforcement agencies could state how many violations were identified last year. "We can document only a handful of violations of the sales laws, while we estimate that almost a billion packs of cigarettes are illegally sold to our youngsters each year," Dr. Sullivan said.

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"The findings boil down to this simple and unacceptable fact: kids can easily buy cigarettes virtually anytime they want to in violation of the law," he said in his prepared testimony. "It is all too apparent that we, as parents, as educators, as health officials and legislators, still do not take the problem of smoking among our children and adolescents as seriously as we should."

Dr. Sullivan said that "the younger a person is when he or she starts to smoke, the more likely that smoking will become a life-long addiction and the more likely are smoking-related diseases. In fact, about 90 percent of adult smokers began their addiction as children or adolescents, so the conclusion is clear: these young smokers account for almost all our future smokers."

Secretary Sullivan pledged to work with states to help improve their control of tobacco sales to minors. The "Model Sale of Tobacco Products to Minors Control Act" which he proposed for states today would:

- Create a licensing system to control the sale of tobacco. A store could sell tobacco to adults only if it avoids selling to minors. Signs stating that sales to minors are illegal would be required at all points of sale.

- Rely primarily on civil penalties to avoid the time delays and costs of the court system. Place primary responsibility for investigation and enforcement in a designated state agency, such as the state health department, but allow local law enforcement and public health officials to investigate compliance.

- MORE -

- o Ban the use of vending machines to dispense cigarettes. To temper economic impact, states might consider a phased approach leading to a complete ban.

"The really disheartening news is that some one million teens start smoking each year. This amounts to about 3,000 each day," Dr. Sullivan said.

"As long as a significant proportion of teens view smoking as a desirable, adult pleasure, and become addicted before they can make a mature judgment, we will never succeed in achieving a smoke-free society," he added.

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Fact Sheet

Smoking and Young People

Office on Smoking and Health
Centers for Disease Control
5600 Fishers Lane
Park Building, Room 1-16
Rockville, MD 20857

In the case of smoking, children and adolescents hold the key to progress toward curbing tobacco use in future generations. If the adult rate of smoking were to continue at the present level the impact of smoking on the future health and welfare of today's children would be enormous. Research has shown that one-fourth or more of all regular cigarette smokers die of smoking-related diseases. If 20 million of the 70 million children now living in the United States smoke cigarettes as adults (about 29 percent), then at least 5 million of them will die of smoking-related diseases. This figure should alarm anyone who is concerned with the future health of today's children.[1]

1. Prevalence of Cigarette Smoking[1]

Eighth and Tenth Graders
(National Adolescent Student Health Survey, 1987)
Smoking, which often leads to a lifetime addiction to nicotine,[5] can begin at early ages.

- **Among eighth graders surveyed, 15% of the males and 17% of the females reported smoking at least 1 cigarette in the last 30 days.**
- **Of these eighth graders, 3% of the males and 2% of the females smoked more than 5 packs of cigarettes in the last 30 days.**
- **Among tenth graders surveyed, 24% of the males and 29% females reported smoking at least 1 cigarette in the last 30 days.**
- **Of these tenth graders, 6% of both the males and females smoked more than 5 packs of cigarettes in the last 30 days.**

High School Seniors
(National Institute on Drug Abuse High School Senior Surveys, 1975-1989)

Reported daily smoking among high school seniors of both sexes has decreased since 1976 in the United States. However, since 1981, smoking rates among high school seniors of both sexes have remained fairly constant. Among high school seniors, females have smoked at greater rates than males since 1976.[1,2,3]

Daily Smoking Among High School Seniors (%)

Year	Total	Males	Females
1975	27	27	26
1976	29	28	29
1977	29	28	30
1978	28	26	29
1979	26	22	28
1980	21	18	24
1981	20	18	22
1982	21	18	24
1983	20	19	23
1984	18	16	21
1985	19	17	21
1986	18	17	20
1987	19	16	20
1988	18	17	18
1989	19	18	19

- In 1989, 19% of high school seniors were daily cigarette smokers (they smoked at least 1 cigarette a day). 11.2% smoked half-a-pack or more of cigarettes each day.[2]

- Following a trend already underway since 1976, a greater proportion of high school senior females were daily smokers than males in 1989. Of the females, 19% smoked, compared to 18% of the males.[2]

- Students who are not planning to attend college smoke at higher rates than those who are planning to attend college. In 1989, nearly 19% of students without plans to complete four years of college smoked half-a-pack of cigarettes or more a day. In contrast, about 8% of those students who planned to complete four years of college smoked a half-a-pack or more each day.[2]

Young Adults Ages 18-24[1]
(National Health Interview Survey, 1987)

Among the U.S. adult population ages 18 and older, males smoke at greater rates than females. However, among the youngest segment of the adult population there is virtually no difference between the two sexes.

- In 1987, 31% of males ages 18 and older smoked, compared to 27% of females.

- In 1987, 28% of males between the ages of 18 and 24 smoked cigarettes, compared to 26% of females. This difference is not statistically significant.

College Students[3]

Adults in college smoke at significantly lower rates than do their peers of the same age who are not in college. Although both sexes smoke at similar rates in the non-college group, among the college students, females smoke at higher rates than males. Females in college have smoked at higher rates than males since 1980.

- In 1988, 7% of the full-time college population smoked half-a-pack or more of cigarettes per day, compared to 23% of adults of the same age who were not attending college full-time.

- In 1988, overall 12% of those in college were daily smokers. Of the males, 9% were daily smokers, compared to 15% of the females. Among non-college young adults of the same ages, 27% of males and 29% of females smoked daily.

Military Population[1]

Smoking rates are higher in the armed forces than in the general population. In 1988, smoking rates for military personnel ranged from 37 to 45%. Reasons for smoking in the military include the inexpensive price of cigarettes, peer pressure, stress, boredom, and lack of other forms of recreation. One study suggests that smoking initiation may often occur among recruits after entering the military.

2. Prevalence of Smokeless Tobacco Use

Smokeless tobacco use has increased in recent years among young males. Smokeless tobacco use among females has consistently been very low.[1]

Males Ages 17-19[1]

- In 1986, 8% of males ages 17-19 reported currently using smokeless tobacco products. Among those surveyed, 12% said that they had used smokeless tobacco products at some point in their lives.

- Between 1970 and 1986, snuff use increased fifteen fold and chewing tobacco use increased more than four fold among males ages 17-19.

Young Males Ages 18-24[4]

- Among males ages 18-24 surveyed in 1987, 6% reported using snuff and 6% reported using chewing tobacco within the last month.

3. Initiation of Tobacco Use[1]

Each day more than 3,000 American teenagers become regular smokers, over 1 million annually. Most regular smokers start in their teens. Among the younger generations, the proportion of smokers who begin smoking during adolescence is increasing, especially among females. A majority of smokeless tobacco use also begins during adolescence.[1]

- In 1986, of the high school seniors who had ever smoked, approximately 25% reported smoking their first cigarette by grade 6, 50% by grade 8, and 75% by grade 9.

- More than half of adult smokers who are in their 40s now, started smoking before they were 18. Nearly 90% started smoking before they were 21.

Proportion of Smokers Who Started Smoking by Various Ages (%)
Age Group in 1990

Age of Initiation	80-84	70-74	60-64	50-54	40-44
< 18 overall	38	40	45	49	52
male	50	49	57	56	57
female	21	26	30	40	47
< 21 overall	66	71	76	83	87
male	77	80	83	86	90
female	50	56	66	80	84

- More than 1/3 of males who use smokeless tobacco products start before they are 16 and 2/3 start before they are 21. The average age at which smokeless tobacco use begins is 19.

4. Young Adult Attitudes and Beliefs about Smoking

A majority of young adults associate smoking with a high degree of personal risk, disapprove of adults who smoke, and believe that their friends would disapprove of them if they smoked. A minority of high school seniors recognize the high level of health risks associated with use of smokeless tobacco products.

- In 1988, 68% of high school seniors; 71% of young adults ages 19-22; and 76% of young adults ages 23-26 associated "great risk" with smoking one or more packs of cigarette per day.[3]

- In 1988, 73% of high school seniors personally "disapproved" of adults 18 years and older smoking one or more packs of cigarettes per day. Among young adults ages 19-22, 74% disapproved and among those 23-26, 66% disapproved.[3]

- In 1988, 76% of high school seniors believed their friends would disapprove of them if they smoked one or more packs of cigarettes per day. Among those ages 19-26, 80% felt this way.[3]

- 1989 data on seniors show 67% associated "great risk" with smoking one or more packs of cigarettes per day. More than 72% reported personally disapproving of this behavior. More than 74% believed their friends would disapprove of them if they smoked one or more packs of cigarettes per day.[2]

- In 1986, 26% of high school seniors surveyed indicated that they believed that regular use of smokeless tobacco products would personally cause "great" harm.[1]

Evidence suggests that young people may underestimate the addictive nature of tobacco use.[1] In 1986, 53% of high school seniors who smoked a half-pack or more cigarettes per day said that they had tried to quit and could not. Survey data from 1985 showed that among those who were daily smokers in high school, nearly 75% were still daily smokers 7-9 years later. This occurred despite the fact that during high school only 5% of these people thought they would "definitely" be smoking 5 years later.[3]

5. Relationship Between Use of Tobacco and Illicit Drugs

Nicotine, found in all tobacco products, is an addicting drug in the same sense as are heroin and cocaine. People who use illicit drugs often also smoke cigarettes. Cigarettes have been called a "gateway drug." In a majority of cases, cigarette smoking precedes use of illicit drugs.[5] Since 1975, cigarettes have been the substance most frequently used on a daily basis by high school students.[3]

- In 1985, 47% of current cigarette smokers ages 12-17 reported being current marijuana users, compared with 6% of youths who were not current cigarette smokers.[5]

- Among youths surveyed in 1985 who had tried both cigarettes and cocaine, 98% used cigarettes first. Only 2% used cocaine before cigarettes.[5]

6. Accessibility of Tobacco Products to Minors

- As of March 1990, the District of Columbia and 44 States have laws for a minimum age for sale or possession of tobacco products. The legal age for purchasing cigarettes in ranges from 16-19. KY, LA, MO, MT, NM, and WY do not have minimum-age-of-purchase laws.[6]

- As of March 1990, only 6 States and the District of Columbia have enforcement provisions for these laws. They are DC[A], IN[A], NE[A], OK[A,B], SC[B], TN[C], and WV[A]. These provisions include: (A) encouraging, minors who purchase tobacco products to divulge sources; (B) providing a bounty for informers; and (C) stating that it is not entrapment to send a minor into a store.[6]

- The 1987 National Adolescent Student Health Survey of eighth and tenth graders revealed that 86% of the students believed it would be easy for them to get cigarettes.[7]

- At least 75,000 cigarette vending machines in the United States are in places from which teenagers can readily obtain cigarettes.[8]

7. Cigarette Advertising

There is evidence that tobacco advertising increases consumption of tobacco products.[9] (For details see pages 500-510 in the 1989 Surgeon General's Report). According to economist Kenneth Warner, the tobacco industry would need to recruit 5,000 new children and teenager smokers each day to keep constant the total number of smokers.[9] The tobacco industry maintains that it does not advertise cigarettes to youths.[10] Under a voluntary code of advertising, adopted in 1964, cigarette companies are barred from advertising in publications "that are directed primarily to persons under twenty-one years of age."[11] Evidence shows, however, that cigarette companies routinely violate this advertising code.

- Cigarette advertisements appear in publications with a large teenage readership. "In *Glamour*, one fourth of whose readers are girls under 18 years of age, cigarette advertising expenditures were $6.3 million in 1985. In *Sports Illustrated*, one third of whose readers are males under 18 years of age, cigarette advertising expenditures were $29.9 million in 1985."[10]

- "Themes in cigarette advertising that emphasize youthful vigor, sexual attraction, and independence are likely to be especially appealing to teenagers and young adults grappling with these issues."[10]

- "Cigarettes promotions placed in movies such as *Superman II* expose large numbers of children and adolescents to these messages. When these movies are shown of television, the ban on broadcast cigarette advertising is circumvented."[8]

- "An ad for free Camel T-shirts in *Sports Illustrated* magazine has led some teen-agers to call a toll-free number and say they're older than the offer's limit of 21. After the shirts arrive, they are mailed coupons for free packs of Camel."[12]

- In February 1990 a marketing firm under contract for R.J. Reynolds Tobacco Company developed plans to promote "Dakota" cigarettes to "18- to 20-year-old women."[13]

8. Health Consequences of Smoking to the Fetus/Infant During and After Pregnancy

Smoking is the single most important preventable cause of death in the United States.[1] People who do not smoke themselves, but who are exposed to the tobacco smoke of others are at an increased risk for certain diseases. This is especially true for the unborn babies of females who smoke during pregnancy[14] and for young children who are exposed to their parents' tobacco smoke after they are born.[15]

- Females who smoke are more likely to have a spontaneous abortion, still-birth, pre-term birth, and full-term low-birth-weight baby that are subject to many health problems.[1]

- Nicotine can pass through breast milk from the mother to the infant.[5]

- Infants exposed to parents' environmental tobacco smoke are twice as likely to be hospitalized for respiratory illnesses--such as pneumonia and bronchitis--as are the infants of nonsmokers.[15]

- Infants born to females who smoked during pregnancy are more likely to die from Sudden Infant Death Syndrome ("crib death") than are babies born to nonsmoking mothers.[14]

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• PRESS RELEASE •

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Release Date: May 31, 1990, a.m.

THE GLOBAL IMPACT OF TOBACCO USE: 500 MILLION DEATHS

World No-Tobacco Day, May 31, 1990

If current tobacco consumption trends continue, one out of ten people living in the world today -- or some 500 million people -- will die of easily preventable, tobacco-related diseases, according to the World Health Organization (WHO).

In an effort to help change current patterns of tobacco use, the World Health Organization proclaims May 31, 1990 as the third annual World No-Tobacco Day and urges smokers to abstain from tobacco for 24 hours in the hope that smokers can break their tobacco habits.

Hiroshi Nakajima, M.D., Ph.D., Director-General of WHO, calls for a renewed assault on smoking and tobacco use which he says should ultimately be eliminated, creating a "tobacco-free" society.

"The consumption of tobacco is a habit responsible for three million premature deaths each year, or approximately one death every 10 seconds," Dr. Nakajima says. "This is all the more tragic, because this habit is the most preventable of all causes of disability and death in the world today."

The principal tobacco-related diseases are cancer (especially lung cancer), chronic bronchitis and emphysema, and coronary heart disease and stroke.

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The impact of tobacco use in many countries is alarming. Deaths attributable to tobacco use number about 700,000 a year in Europe, 400,000 a year in the United States, and 400,000 a year in the Soviet Union. Mortality and morbidity data for the developing countries are less accurate, but the toll from tobacco use is believed to be rising in China, Brazil, Egypt and Thailand.

Not only are smokers dying from their tobacco habit, but they are dying at an earlier age than non-tobacco users. Recent WHO data show that the lives of smokers of middle age (35 to 69 years of age) can be shortened by 15 - 20 years because of tobacco use.

The impact of tobacco production use in numerical terms is staggering. World cigarette production continued to increase in 1988. Profits from this trade are high, as are the tobacco taxes collected by governments.

"Strong political will and commitment are needed to stop people's dependence on tobacco, and governments' 'addiction' to tobacco taxation revenue," says Dr. Nakajima.

One worrisome trend for WHO experts is the targeting by tobacco companies of children and young adults. This trend is why the theme of this year's World No-Tobacco Day is "Childhood and Youth Without Tobacco".

"It is not enough to offer young children and adolescents the choice between tobacco or health," says Dr. Nakajima. " For the sake of their health, it is necessary to guide them in making the choice. Every child should have the right to grow up without tobacco."

The tobacco industry spends millions of dollars on advertising which presents a flattering, often dazzling, image of smoking. Smoking is pictured as part of a dream, a symbol of social status, and an integral ingredient of life.

In some quarters, this advertising is working. It is estimated that every day about 3000 adolescents take up smoking in the U.S. The majority of new smokers are hooked before the age of 19. However, the fact is that tobacco use is starting at earlier ages, sometimes as early as eight, and on the average, between 11 and 13, particularly among young women in industrialized countries.

The puzzle rests, therefore, in understanding why young people start smoking and why they continue. Data collected from Canada, the United Kingdom and the U.S. show that adults from the lower socioeconomic groups are more likely to smoke than those from higher income groups and that a lower level of parental education also is a factor in their children taking up the habit. Other studies have shown that if a mother smokes, her children are more likely to become smokers; unemployment is a factor among women.

In addition, adolescence is the dynamic period of development when the young begin to draw away from their parents and to develop intense relationships with peers from whom they seek approval. Many young people see tobacco use as normal social behavior, and this is often reinforced by the media.

Advertising links tobacco with fun, maturity, and an image of the "modern" man or woman. There is evidence that advertising directly influences the decision to start smoking. Studies show that in

countries such as Norway, where tobacco advertising has been restricted, there has been a reduction in smoking prevalence among young people.

One example of the influence of advertising is the campaign created to promote "smokeless" tobacco - snuff and chewing tobacco which was aimed at teenage boys in North America and Scandinavia. According to studies cited by WHO, in the U.S., more than $35 million was spent on television and magazine advertising to promote snuff and chewing tobacco in 1985, involving celebrity promotions, distribution of free samples to college students, and magazine advertisements.

In the U.S., sales for snuff rose by 55 percent between 1978 and 1985. It is estimated 16 million people in the U.S. use smokeless tobacco today. The International Agency for Research on Cancer and the United States Surgeon General have concluded that the use of smokeless tobacco causes oral cancer.

Tobacco use can affect infants even before they are born. The fetus of mothers who smoke while pregnant can suffer from Fetal Tobacco Syndrome. This syndrome is caused by nicotine and carbon monoxide entering the bloodstream of the fetus and damaging the supply route for oxygen and food. This can lead to lower birth weight, poor growth and size at birth, and possible congenital defects and infections. Smoking during pregnancy has been associated with premature birth, spontaneous abortions, and fetal and perinatal deaths.

Risk associated with smoking continue after birth and affect the newborn baby and other children at home. Infants can absorb harmful chemicals from breastmilk.

Few regular smokers are aware that over the course of a year, their children may be absorbing, through "passive" smoking, the amount of nicotine contained in 30 to 80 cigarettes. One study found that some Japanese schoolchildren had smoke-related chemicals in their urine in direct proportion to the number of cigarettes their parents smoked.

Health problems among children who live with smokers include:

- Higher incidence of respiratory infections;
- More common chronic cough, phlegm and wheezing;
- Slower growth and lung development; and
- More common chronic middle ear infections.

WHO says there is no single, proven way to promote non smoking and to prevent the use of tobacco by adolescents. However, WHO believes a number of strategies, when combined, have proven effective:

- Appropriate and culturally-specific health education;
- Peer-led, anti-smoking initiatives in schools;
- Prohibiting cigarettes sales to young people and limiting easy availability;
- Increasing the cost of cigarettes. For example, by increasing taxes; and
- Promoting the setting aside of no-smoking areas, especially in public places.

* * *

THE TOLL OF TOBACCO:
1.7 MILLION DEATHS IN DEVELOPED COUNTRIES

Lung cancer	400,000
Other cancer	200,000
Chronic bronchitis and emphysema	220,000
Coronary heart disease and stroke	620,000

Data for developed countries in 1985

Source: World Health Organization, 1990

CIGARETTE OUTPUT BY MAJOR PRODUCERS [1]
Millions of Pieces

Country	1983	1988 [2]
China	968,800	1,525,000
United States	667,000	694,500
USSR	368,700	392,500
European Community		
West Germany	155,942	162,092
United Kingdom	141,948	114,000
Spain	63,600	78,400
Italy	83,697	66,486
Netherlands	45,303	61,724
France	62,147	53,307
Greece	25,336	28,050
Belgium-Luxembourg	28,042	26,937
Portugal	14,329	14,610
Denmark	9,763	11,144
Ireland	7,534	7,750
EEC Total	637,641	624,500
Other Major Producers		
Japan	306,320	267,600
Brazil	129,200	157,900
Indonesia	93,275	140,000
Poland	82,823	89,684
Bulgaria	75,200	88,300
Korea, South	75,279	86,244
India	80,447	80,400
Philippines	57,812	66,850
Turkey	61,477	60,155
Yugoslavia	58,439	58,500
Canada	63,949	53,858
Egypt	44,000	51,000
Mexico	49,242	48,630
Aggregate Total	3,819,604	4,485,621
World Total [3]	4,556,107	5,270,514

Notes: 1 - Estimates are included in the absence of data.
2 - Revised.
3 - World total includes incidental countries not listed.

Source: Foreign Agricultural Service, United States Department of Agriculture- August 1989

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